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Development of criteria, on a competency based model, for the selection, evaluation and training of family care foster parents.

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DEVELOPMENT OF CRITERIA, ON A COMPETENCY BASED MODEL, FOR THE SELECTION, EVALUATION AND TRAINING OF FAMILY CARE FOSTER PARENTS

A Dissertation Presented

By

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Dedicated to my parents,

Flora and Jeremiah Buckley

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Special acknowledgment belongs with my family--my parents, sister and brother. Their patient encouragement and constant love have been major contributions to the completion of this endeavor.

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ABSTRACT

Development of Criteria, on a Competency Based Model, for the Selection, Evaluation and Training of Family Care Foster Parents

(September, 1981)

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Recent advances in the field of mental retardation have had an impact on the roles and functions of individuals providing direct care services. This has been particularly evident in the area of residential services where new community based service models, emphasizing client training and development in addition to care, are placing more responsibility on those in direct service roles to assume "professional" functions. Of the implications resulting from these changes, the most important to this dissertation is the resultant need to design selection and training systems which will assure the preparation and development of a competent direct care work force.

This study focused on the direct service component of the Specialized Home Care Project in Massachusetts.

Specialized Home Care, based on a foster care model, is a community living arrangement in which families or individuals (Care Providers) provide residential care, supervision and training within their own homes for children and adults with mental retardation.

Past approaches to Care Provider selection and training, paralleling traditional clinical approaches used in generic foster care, have been criticized for their lack of standardization and objectivity. This study was directed toward the development of an alternative approach utilizing a competency based model. The specific purpose of the study was to identify competencies which are significant to superior performance as a Care Provider. Such criteria provide the empirical foundation upon which a competency based selection, evaluation and training system can subsequently be designed.

The study methodology entailed two phases of data collection and analysis. In the first phase, Job Element Analysis, a job analysis process researched and designed by Ernest Primoff of the U.S. Civil Service Commission, was carried out. Following Job Element Analysis techniques, 140 skills, attitudes, abilities and areas of knowledge related to superior performance as a Care Provider were generated and rated by a Job Element Panel. The panel was composed of incumbent Care Providers who had been designated as

outstanding performers as well as experienced supervisors of Care Providers. Tabulation and analysis of panel ratings resulted in a refined listing of 106 competencies which served as the hypothetical basis for the remainder of the study.

The second phase of data collection and analysis was intended to formally assess the validity of the 106 competencies identified in the first phase of the study. Two questionnaires were designed whereby both self and supervisory assessment of larger criterion groups of average and superior Care Providers on each of the hypothesized competencies could be obtained. Brief demographic data was also solicited through the questionnaire.

Questionnaires were completed and returned by 112 Care Providers and their supervisors (response rate = 68%). Based on a general rating of each Care Provider by the supervisor, the superior (N=65) and average (N=47) groups were established.

Data analysis involved a comparison of the superior and average groups. Self and supervisory mean ratings of groups on each of the competencies were statistically analyzed using a t-test for independent means. Frequency distributions of each group on demographic data were also compared.

Results of statistical analysis showed a significant

difference between the superior and average groups for all but two of the hypothesized competencies. Comparative analysis of demographic data showed little difference between groups except in the areas of experience with mental retardation prior to Specialized Home Care and training in addition to mandatory Specialized Home Care training. The superior group was composed of approximately 20% more members with such experience and training.

The final listing of competencies validly related to performance as a Care Provider include: (1) 10 mandatory competencies which should be used for initial screening of applicant Care Providers; (2) 17 competencies on which applicants should be assessed during the home study process; and (3) 17 competencies which are not practical to expect of applicants but which are highly suitable for training curricula and periodic evaluations.

The author provides several recommendations for continued application of the results. Since this is the preliminary stage of competency system development, she stresses the need for further definition of the identified competencies in standardized and measurable terms. Also recommended is further research whereby the utility of a competency based Care Provider selection, training and evaluation system is assessed in a pilot study.

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INTRODUCTION

The past decade has been heralded as a period of rapid and progressive reform in services for individuals with mental retardation. Right to treatment and right to education litigation have paved the way to state and federal legislation mandating an increase in both the quality and quantity of services (Abeson, 1973; Friedman, 1980). New concepts in programming have shifted the focus of service delivery from large isolated institutions to smaller, integrated community based settings (Menolascino, 1977; Wolfensberger, 1972). Educational and psychological research, demonstrating effective instructional techniques for even those with severe limitations, has dramatically changed the content and purpose of educational, vocational and residential programming (Berkson & Landesmann-Dwyer, 1978).

Such broad-based social, legal and technological advances have created a host of problems and needs related to the recruitment, selection and development of a competent work force. The problem of manpower utilization and development has become particularly acute in the area of residential programming where the preponderance of

service has been and continues to be provided by a largely non-professional direct service staff (Ebert, 1979; Ingalls, 1978).

Within recent years the residential service system for persons with mental retardation has been undergoing a major transition. Community residential alternatives in the form of small family or staffed sites have resulted in a diversified service structure with an increasingly greater emphasis on the quality and benefits of care. With a new emphasis on the "habilitative" responsibility of residential services, the non-degreed direct caregiver is being given more and more teaching, advocacy and counselling functions once believed to be the sole province of the professional (Gettings, 1980). Research has produced compelling documentation of the numerous inadequacies of resident care practices in institutional settings (Baroff, 1980; Pratt, Raynes & Roses, 1977) as well as the significant impact of the non-professional caregivers on the growth and development of their retarded clientele (Bjaanes & Butler, 1974; Pratt, Bumstead & Raynes, 1976; Zigler & Balla, 1977). Yet, until recently, alarmingly little attention has been given to the training and development of persons providing direct services in community residential alternatives (Dellinger & Shope, 1978; Fiorelli, 1979; Peck, Blackburn & White-Blackburn, 1980).

This study focuses on the development of the

direct service component of the Specialized Home Care Project in Massachusetts. Specialized Home Care is a community living arrangement in which families and individuals provide residential care, supervision and training, within their own homes, to retarded children and adults. This system of residential care, often regarded as a surrogate family life experience, is most commonly referred to as specialized foster care or family care.

Background and Statement of the Problem

Through the 1970's, the family care model has become one of the most popular alternatives to institutionalization across a wide range of human service populations in need of residential care. There is a well documented commitment to the development of family care programs across the country supported by a national trend to develop local community services for individuals in need. The total population served in foster family care homes has steadily increased in recent years (Mnookin, 1973; Prosser, 1978). In Massachusetts, the Departments of Mental Health, Public Welfare, Youth Services and Elder Affairs have all implemented programs based on this less restrictive model of care for a wide variety of clientele including the emotionally disturbed, the mentally retarded, criminally involved youth, the physically handicapped and the elderly.

The increased development and use of family care, as well as a number of other community residential models, for individuals with retardation has largely resulted from the deinstitutionalization movement. Deinstitutionalization has been the subject of a variety of interpretations and meanings, but it is commonly considered to have a two-fold objective of "avoiding placing [retarded] individuals in institutions and discharging as many as possible of those already there" (President's Committee on Mental Retardation, 1977, p. 262). Another goal frequently associated with deinstitutionalization has been stated by the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974) as the "establishment and maintenance of a responsive residential environment which protects human and civil rights" (p. 5), reflecting a justified concern that the dehumanizing conditions of custodial institutional care be replaced by quality services within the community.

The notion of quality of care has particular relevance to the development of family care services for the retarded (Intigliata, Miller & Cooley, 1979). While there has been enthusiastic support of foster care or alternative family placement as an important option in the continuum of community services for the retarded (Menolascino, 1977; Wolfensberger, 1972), an equivalent amount of concern has been generated about the capacity of

the family care providers to adequately manage the unique training and therapeutic needs of the retarded consumer of this service. In a discussion of foster care for the retarded, Begab (1970) emphasizes that parental adequacy for normal children does not guarantee adequacy in the case of the retarded.

A statewide study of developmentally disabled children in foster care in Massachusetts clearly supports this concern. Frequently reported cases of inadequate or inappropriate treatment were due to lack of social worker support and supervision as well as foster parent inability to cope with the needs of the child in care (Gruber, 1974).

Browder, Ellis and Neal (1974) advise that "there should be caution in the unrestrained optimism for foster care programs until more sophisticated systems for parent selection, training and support are developed" (p. 36). In their study, over half the placements assessed were in need of substantial improvement. Acceptance of the child's handicaps and skills in monitoring those handicaps were cited as competencies frequently lacking in foster parents and having a subsequent detrimental effect on the development of the handicapped child.

In response to these concerns, a number of states have passed legislation to create "specialized" family care programs for the retarded (Bruininks, Hill &

Thorsheim, 1980). While there is no standard criteria for the make-up of such programs, they typically feature increased support to families, additional supervision of the home, provisions for training of families and financial remuneration of the family care providers for the specialized services they provide to the child or adult in their care. Within this context, the role of the family care provider has expanded beyond the traditional foster parenting role. In addition to the responsibility for basic care and nurturance, the family care providers in these specialized programs are also expected to assume some essential teaching, counselling and medical monitoring functions.

Provencal (1980) discusses the importance of provider qualifications, training and professionalism in the development of such a program. He criticizes the inordinate focus on client pre-requisite skills and characteristics related to "success" and "failure" in foster home and other community placements which perpetuates a "blaming the victim" mentality. He stresses that a critical variable of success in placement is the provider's skill and expertise in the provision of an environment wherein individual clients can adjust. In emphasizing the need to provide training and support to those providing services within community residential alternatives, he states: "We can develop all the residential alternatives

we want, but if people keep bouncing back into institutions because the folks [staff] out there are not ready for them, we haven't done very much" (Ibid., p. 28).

There is general agreement on the need for carefully selecting family care providers, and for preparing them, through training and supervision, with the necessary qualifications to provide quality services. There is less concensus, however, as to what those qualifications are or how they are to be assured. A broad range of personal qualifications have been suggested in descriptive literature (Begab, 1970; Mamula, 1973). However, there has been very little empirical research providing data on what particular qualifications, whether personal or professional, are necessarily related to success as a family care provider. This, in turn, weakens efforts to design effective systems for the preparation and development of care providers. Selection and evaluation decisions tend to become highly subjective, training objectives more diffuse, standards less defined and the overall quality of service less assured.

In summary, there has been both optimism and concern about the use of family care as a community residential alternative to institutionalization. A major area of concern is that of family care provider capacity and competence to adequately respond to the developmental, training, and emotional needs of the retarded adults and

children in their care. While specialized family care programs have been developed in response to these concerns, there is currently a lack of data on what qualifications and training a specialized care provider must have to perform successfully. The identified problem of this study is the lack of a systematic and objective process by which to base decisions on the selection, evaluation and training of the family care provider.

Approach to Problem

Similar problems in other areas of human services are being addressed through the use of a competency-based approach. Competency-based programs are founded on a basic tenet that competence, as defined by the knowledge, skills, abilities and attitudes which an individual possesses, is the cause of effective performance (Klemp, 1979). Competency "refers to proficiency within some limited, usually small, area of work. A worker may have competencies and yet not be competent enough to serve clients" (McPheeters, 1977, p. 5). Certain competencies, therefore, are crucial to effective or competent performance in certain jobs. If human service jobs are defined in precise terms of competency requirements and human service workers are selected, credentialed, trained and evaluated based on these requirements, the client or consumer is assured of more competent service.

Though the competency-based approach has been most commonly applied to defining curriculum content and student exit requirements in teacher preparation programs, there has been a rapid extension of the concept to other personnel preparation programs. Physicians in Illinois, Texas and Michigan are being trained through competency-based programs. Nursing, allied health programs and other training for paraprofessionals are also adopting competency-based educational programs (Houston, 1974).

Beyond an educational or training function, the competency concept is also useful for improving systems of credentialing and licensing. Selected, significant competencies are used as the minimum criteria for state approval of individuals for employment in various human service occupations. Once again, the field in which this process of licensure has been most prevalent is education. Florida, New Jersey, Pennsylvania and Texas were among the first to utilize the competency concept within their state teacher certification programs as a measure of quality assurance for educational manpower (Houston, 1974).

In the area of paraprofessional manpower credentialing, the competency-based approach has proven to be a particularly useful resource. A majority of the paraprofessional positions in the human service field have no corresponding program of academic preparation, but do require a certain level of expertise. A competency-based

licensing or credentialing process can serve in lieu of a college or academic degree. Specified competencies are measured through interview, observation and testing of the individual paraprofessional; outstanding competencies are identified; a plan for acquisition of outstanding competencies is developed; and upon successful completion of this plan, the individual is credentialed (Gerstein, 1977). In addition to insuring minimum performance standards and a personal sense of status for non-degreed employees, this licensing procedure serves as a catalyst for increased recognition and delegation of responsibility by professional personnel. The paraprofessional employee becomes more efficiently and effectively utilized for more than custodial or non-skilled functions.

By developing a competency-based system for the position of family care provider, several needs can be addressed.

1. Identification of competency requirements for effective performance provides agency standards for assessment and selection of care providers based on objective criteria for effective performance. Reliance on a subjective clinical approach is reduced.

2. Agency decisions on the content and format of a training curriculum are based on care provider competency needs and strengths. Training efforts become more

focused and goal-oriented. Care provider learning can be associated with concrete, on the job situations which are related to the need for specific competencies.

3. The competency-based approach is highly individualized. Care providers are able to demonstrate competency attainment within the context of their specific experiences as opposed to the theory-based approach of traditional personnel development systems.

4. A competency-based approach places an emphasis on accountability. The agency is responsible for clearly stating pre-service and in-service competency requirements. The care provider is given a clear statement of expected behaviors and is held accountable for demonstrating those behaviors. Ambiguities about performance and responsibilities can be reduced.

5. A competency-based system provides an information source on overall manpower capabilities and potential. This information is critical to the continuing process of planning, development and evaluation of the family care model for future use as an alternative residential option.

In a 1977 symposium on mental health and human services competency, Paul Pottinger (1977b) of the Institute for Competence Assessment outlined the four

essential stages of developing a valid competency-based system of manpower development as follows:

1. Analyze the elements of competence in order to evaluate performance.
2. Discover what the critical ingredients of successful performance are.
3. Determine if or how to test personnel for selection or promotion.
4. Develop the content for meaningful, useful training. (p. 17)

This study concentrates on the first two stages which supply the framework or foundation for the final stages of constructing the system.

Purpose of the Study

This study is directed toward the development of a systematic and objective process for the selection, evaluation and training of family care providers. The purpose of the study is to identify criteria, on a competency-based model, for the selection, evaluation and training of family care providers. These criteria are derived from an analysis of the skills, abilities, personal characteristics and areas of knowledge (competency requirements) which are highly related to successful performance as a care provider for the Massachusetts Specialized Home Care Project.

Specific objectives. The specific objectives of the study are to:

1. Identify competencies which are significant to superior performance as a care provider;
2. Identify competencies useful for consideration in the initial screening and evaluation of applicant care providers;
3. Identify competencies highly suitable for inclusion in pre-service and in-service training curricula.

These objectives are attained through the use of a job analysis methodology developed by Ernest Primoff (1975) of the U.S. Civil Service Commission and an adaptation of procedures developed at the Institute for Competence Assessment in Boston for the development of competency-based manpower systems (Pottinger & Klemp, 1976). The specific methodology of the study and theory related to it are discussed in Chapters II and IV of this dissertation.

Significance

This study provides information regarding the desirable qualifications of the Specialized Home Care Provider. The results of this study should provide practical data to various individuals and groups involved with the provision of services for the mentally retarded as well as those involved with the implementation of family care programs for other populations.

This study contributes to a very limited body of research on the family care model. The information obtained should assist the Specialized Home Care Project and similar programs for the retarded in developing evaluation, supervision, and training systems. It could also benefit the growing number of family care programs serving other specialized populations.

The field based data generated in the final phase of the study will provide useful descriptive and evaluative data for administrators and program planners. The competencies assumed to be possessed by family care providers can be compared with actual competency as reported by care providers and their supervisors. Such data can be used for determining current and potential capacity of the Specialized Home Care Project specifically and family care programs generally to meet the needs of a retarded population. Management decisions regarding future modification, expansion and development of this program model will be enhanced by objective program data.

This study may also assist those individuals and groups involved in the planning and implementation of manpower development systems. In the field of retardation, the movement from custodial, institutional services to community based, habilitative services is requiring more and differently qualified personnel. There has been much discussion about the potential transfer of chronic insti-

tutional problems and abuses to community programs as deinstitutionalization takes place without the necessary pre-service and in-service training of manpower delivering services (President's Committee on Mental Retardation, 1977). The benefits of a competency based approach to manpower development, particularly for the non-degreed direct service employee, have been discussed in an earlier section of this chapter. The procedures and methods described in this study should prove instructive and informative to others involved in competency based manpower development efforts.

Finally, the information provided will also benefit those working with biological parents of the retarded. As a result of the deinstitutionalization movement, greater effort is being directed toward maintaining the retarded individual with his or her own family. One major approach has been to reduce the stressful impact of a retarded child on the family by increasing the competence of biological parents to manage their child through various forms of parent intervention and training (Fotheringham & Creal, 1974). Though there are admittedly distinct differences between substitute parents and biological parents, there are also obvious similarities in the day to day parenting experience. There are areas of competence common to both biological and foster parents who effectively parent a retarded child. The competencies

identified by this study will provide useful information for biological parent training, intervention and support programs.

In summary, the data to be obtained through this study will contribute significantly to a limited base of information on the Specialized Home Care Project and similar foster family care programs for the retarded. In addition, it will yield information which has potential practical application and use for family care programs supporting other populations, manpower development programs and biological parent support programs.

Definitions

Care Providers: individuals who provide residential care and training within their own homes for mentally retarded children or adults; also referred to as family caretakers or foster parents.

Competency: proficiency within some limited area of work.

Competency-based: based on clearly defined specifications of what constitutes competence.

Job Element: a worker characteristic which influences success on the job, including combinations of abilities, skills, attitudes and areas of knowledge.

Subelement: a worker characteristic related to the successful performance on a specific part of the job.

Subelements help to define the particular applications of an element for a particular job situation. For example, Ability to Carry Out a Home Training Program may have subelements: 1) ability to assess client needs; 2) ability to prioritize client need; 3) ability to write behavioral objectives; 4) ability to develop training strategies, and others. Subelements are specific enough to serve as the basis of home study assessments, performance evaluations and other measuring devices.

Limitations

The job analysis process used in the study does not take into consideration the differing levels of functioning and disability of mentally retarded clients and the differentiated competencies related to those abilities. The process does not identify specific competencies which are critical to the competent care and training of specific types of clients.

The care providers and supervisors participating in the study provide services to a retarded population in Massachusetts. The competency requirements established may not be generalizeable to programs outside of Massachusetts or to programs serving other specialized populations.

Organization of the Dissertation

This dissertation is organized into six chapters. Chapter I provides an introduction to the study including an explanation of the problem to be addressed and the approach to the problem. It concludes with a statement of the purpose, specific objectives, definitions and possible significance and limitations of the study. Chapter II reviews selected literature and research which is related to the study. The three major areas considered in this chapter are: 1) an investigation of literature and research related to the development of current concepts and practices in residential care; 2) a review of the roles, functions and training of foster parents as well as the origins and development of family care for the mentally retarded; and 3) an overview of the competency based movement with an emphasis on methodologies for the identification of competence. Chapter III is devoted to a presentation of the Massachusetts Specialized Home Care Project outlining program philosophy, structure, policy and procedure in relation to care provider role and function. Chapter IV provides a detailed examination of the study methodology and procedures. Chapter V presents and analyzes the results. A summary of the study, followed by conclusions and recommendations, is contained in Chapter VI.

C H A P T E R I I

REVIEW OF SELECTED LITERATURE AND RESEARCH

Introduction

In a recent study using the Delphi technique (Roos, S., 1978), thirteen nationally recognized experts in the field of developmental disabilities submitted projections regarding residential services during the next twenty years. While a majority of the experts saw group homes as the primary residential service in the 1980s, the preferred pattern was adoption or foster care and greater retention of retarded persons in their own homes with governmental assistance. Perhaps because of this vision of smaller, decentralized residential sites, the experts also predicted greater status and higher pay for those personnel providing direct service.

As might be expected, these predictions mirror much of the recent optimism regarding improved residential services for persons with developmental disabilities. Smaller "homelike" settings have been promoted as desirable vehicles for deinstitutionalization and integration of the handicapped in the community. Likewise, the importance of direct care services as a key force in the

effective provision of services has also been recognized.

The following review of research and literature related to this study considers some of the developments behind these predictions and some of the practical considerations related to implementation of these visions.

Development of Community Based Residential Services

The recent development of community living opportunities for persons with mental retardation signifies a marked break from a long and arduous pattern of institutional care. Institutionalization has been the predominant form of government sponsored residential service for the retarded since the mid-19th century with its most rapid expansion occurring in the first half of this century (President's Committee on Mental Retardation, 1977). During this period institutional populations grew at a phenomenal rate from 7,000 in 1900 (.09 per 1000 of the general population) to 190,000 in 1969 (1 per 1000) (Ibid.). This rapid growth rate is usually attributed to the negative effects of the eugenics scare in the first quarter of this century (Wolfensberger, 1976), the difficulty in developing services beyond the institutional model, and the advances of medical science in saving and prolonging life (President's Committee on Mental Retardation, 1977).

During this period of institutional expansion, minimal attention was given to the deteriorating conditions of overcrowded institutional facilities or to the development of other more effective methods of residential care. Programs for the release of suitable individuals to the care of their parents, relatives, volunteers or employers did exist. But lacking fiscal, public and professional support, these programs of deinstitutionalization were virtually insignificant in reversing the pattern of large scale, segregated custodial care (Begab, 1975; Seltzer and Seltzer, 1978).

It was not until the 1960s that documented evidence of a concerted effort to reverse the trend of institutionalization exists. Based on the collective efforts of disenchanted parents and professionals the quality of institutional care came under heavy criticism. Alarmingly inhumane conditions were exposed through television documentaries and other forms of media (Begab, 1975; Blatt & Kaplan, 1966), giving the plight of the mentally retarded national visibility and capturing the public sympathy. This in turn created an urgent press for reform.

Normalization, a human management philosophy conceptualized in Northern Europe, greatly influenced the nature of the reform. Based on the philosophy of "making available to the mentally retarded the conditions of everyday life which are as close as possible to the norms

and patterns of the mainstream of society" (Nirje, 1969), the concept had immediate appeal to the parent and professional reformist groups. It was quickly adopted by a number of American leaders in the field (Wolfensberger, 1972) and became an integral force in defining a new standard of service for the retarded.

The direct implication of the normalization principle, as it has become referenced by Wolfensberger (1972), was deinstitutionalization and ". . . maximal feasible integration of deviant people into the cultural mainstream" (p. 209). Coupled with the mounting criticism of the quality of institutional care, the normalization principle catalyzed the development of community-based residential alternatives to the institution.

Legal developments provided further support for this movement. Class action suits on behalf of the institutionalized retarded have resulted in now numerous litigative rulings confirming the rights of the retarded to habilitative services in the least restrictive setting possible (Gilhool, 1976; Halderman v. Pennhurst, 1977). Federal legislation has also been enacted. P.L. 94-103, the Developmentally Disabled Assistance and Bill of Rights Act, specified "the basic rights of persons with developmental disabilities to appropriate treatment, services and habilitation 'designed to maximize the developmental potential of the person' and 'provided in the setting that

is least restrictive of the person's personal liberty'" (President's Committee on Mental Retardation, 1977, p. 98).

Recent changes in the patterns of residential care reflect these social, ideological and public policy developments. The population of large-scale institutional facilities has decreased from approximately 190,000 in 1969 to 155,000 in 1979 and has recently been decreasing at an average rate of just under 4% per year (Scheerenberger, 1981). Conversely, community based residential facilities have rapidly expanded. According to a national survey, the population of 87.9% of the 5,038 community facilities identified in 1977 was well over 83,000 (Developmental Disabilities Project on Residential Services and Community Adjustment, 1978), reflecting a doubling of capacity over the previous three years.

Community residential care has therefore begun emerging as the prime vehicle of reform in residential care for the mentally retarded. Although institutional redevelopment has also occurred, it has become judged as the most undesirable option in the movement toward normalization and placement in the least restrictive setting.

Types of Community Residential Care

Community residential services have assumed a variety of forms. The Developmental Disabilities Project

on Residential Services and Community Adjustment (1979) identified over 37 types of facilities in 1977 and noted that "there is no standard classification system which categorizes this wide range of residential services for retarded persons" (p. 1).

Developers of community-based residential care have created a diverse range of service models. Independent, semi-independent and fully supervised apartments provide what some now consider the most normalizing living arrangements for adults (Seltzer & Seltzer, 1978). Alternative family care, for both children and adults, was one of the previously existing models for community placement from the institution. It has become increasingly modified to reflect the newer programmatic concepts of normalization and habilitation now embraced by the field of mental retardation. Boarding homes provide a less restrictive form of family based care for more independently functioning individuals (Bruininks, Thurlow, Thurman & Fiorelli, 1980). Community residences or halfway house facilities, serving larger groups with fulltime staff supervision, were extremely popular at the onset of the deinstitutionalization movement. They have been widely used as an initial community entry point for persons leaving the institutions (Ibid., 1980). Community residences for children and adolescents are also known as hostels or family care homes. Support to biological fami-

lies in the form of respite care is another option conceived as a preventive component of a residential service system (Menolascino, 1977). Adoptive home placement for children has now become a most desirable and realistic option (Soeffing, 1975).

However unique and diversified the program, the commonly assumed goal of the movement to establish community-based care has been the provision of normalized, habilitative community living experiences. Recent assessments by leaders in the field (Apolloni, Cappucilli & Cooke, 1980) have generated a growing concern about the quality of life in community facilities and the failure of many residential sites to approximate this goal. What is being recognized is that proximity to the community and smaller, more individualized sites may indeed be a substantial improvement over the large, segregated institution, but that these factors do not a priori change the quality of care within the residential site.

Research on the quality and success of both institutional and community residential care has directed attention to the importance of direct care services.

Research on Residential Settings

Since the early criticism of institutional care, considerable research has focused on the effects of residential settings on the development and behavior of the

retarded. Throughout the 1970s researchers have seriously looked at environmental characteristics as contributing to the development of the retarded individual. This research, an outgrowth of research in the mental health field on treatment environments (Jackson, 1969), has been conducted in both institutional and community settings.

Though the researchers consistently stress the preliminary nature of their findings, tentative conclusions regarding direct care services can be made. There is great variability in care practices across institutional and community facilities. Size of facility does not consistently predict quality or type of care (Baroff, 1980) nor do staff to resident ratios (Zigler & Balla, 1977; McCormick, Balla & Zigler, 1975). Resident oriented, as opposed to facility oriented, care practices within living units have been found to affect client development (King, Raynes & Tizard, 1971; Tizard, 1964). These differences in care practices have been associated with the quality of staff and resident interactions (Bjaanes & Butler, 1974; Pratt, Bumstead & Raynes, 1976), the intensity of programming (Eyman, Silverstein, McLain & Miller, 1977), consistency of caregiver (Zigler & Balla, 1977), and involvement of the caretaker in decision-making regarding care (Pratt, Raynes & Roses, 1977). The training (McCormick, Balla & Zigler, 1975), previous experience and attitudes (Butler & Bjaanes, 1977) of

direct care staff have also been suggested as factors related to the habilitative quality of the residential site.

Several studies have attempted to identify factors related to "success" and "failure" in community placements. Client variables, such as IQ, sex, age and diagnosis, have not been found to influence the probability of remaining in placement. "The literature concerning the post-institutional adjustment of the mentally retarded is replete with inconclusive, discrepent and contradictory findings" (McCarver & Craig, 1974). Incidents of maladaptive behavior have been noted as resulting in a considerable number of placement failures (Ibid.), but caregiver skill in handling of behavior problems may decrease the influence of this variable (Nihira & Nihira, 1975).

Sternlicht (1978) reports that a few studies have considered caretaker characteristics in relation to adjustment or failure. Emotional stability, attitudes and health of the caretaker may be correlated with the maintenance of a placement. Competence and skill of the caretaker have not been considered in relation to success or failure, although several propositions about the importance of direct care staff in shaping the quality of care in a living environment have been made.

Freedman (1976) notes that ". . . predictor

variables related to the community settings in which subjects are placed and their community experience have been noticeably absent in these studies [of community adjustment]" (p. 97). Seltzer and Seltzer (1978) comment:

> Only recently have theoretical models which focus on the effect of the environment on individual behavior been seriously recognized by investigators in the field of retardation. Both the normalization principle and the behavioral model seek to maximize individual performance through the intentional design of the environment. The recognition that environmental features as diverse as architectural design, teaching strategies, and professional attitudes have a profound impact on individual behavior reflects a significant philosophical shift in the way retardation is now conceptualized. (p. 15)

Thus the changing perspective on the responsibilities and functions of the residential setting have placed greater emphasis on the habilitative role of direct care services.

The Changing Role of Direct Care Services

Recent changes in ideology and programmatic perspective have resulted in increased expectations and demands on the residential facility to provide habilitative care. The developmental model (Menolascino, 1977), stressing individual potential for progress no matter how severely impaired (Scheerenberger, 1976), has broken a cycle of custodial care. The current focus is on the educational and therapeutic outcomes of residential care with decreasing emphasis being attributed to physical care and medical functions.

This modification in programmatic goals has been recognized by many as having critical implications for staffing (Bensberg & Barnett, 1964; Bruininks, Thurlow, et al., 1980; Cohen, 1970; Linton, 1971; Peck et al., 1980).

> The primary goal of programs for the mentally retarded should be to increase the adaptive behavior of the individual by modifying the rate and direction of behavior change . . .
>
> There should be sufficient, appropriately qualified, and adequately trained personnel to conduct the residential living programs in accordance with standards specified. (National Association for Retarded Children, 1972, p. 14)

An early response to the recognition that the staff services of the residential setting needed to be upgraded was the pursuit of professional resources (Cohen, 1970; President's Committee on Mental Retardation, 1977, Chapter 12). The direct care staff of the institution in particular had been unable, supposedly for lack of professional expertise, to carry out an adequate level of relevant programming. The custodial care practices of the residential institution had been provided by untrained aides or attendants. Though due recognition had been given the obstacles to the provision of direct care services in overcrowded, understaffed institutions (Ingalls, 1978, pp. 417-418), the major manpower development activities were intended to cultivate the professional ranks. This course of action was unable to meet the need. It became "increasingly apparent that professionals are

unable . . . to give direct service to a majority of the institutionalized retarded . . . Professionals are beginning to function primarily as consultants, teachers, trainers, and supervisors" (Roos, P., 1970, p. 38). The problem of professional deployment has become even more acute as the rise in community residential programs has created an even greater manpower shortage. Direct care services in both institutional and community settings have remained largely the responsibility of individuals without professional credentials.

Attention has begun to be given the qualifications of direct care staff to adequately implement habilitative programming. "As the sociopolitical commitment to alternative living arrangements services continues to broaden, the need for trained, competent direct service personnel will become increasingly critical" (Bruininks, Thurlow et al., 1980, p. 88). After an extensive survey, Bruininks, Kudla, Wieck and Hauber (1980) identified problems related to recruitment, training and reducing staff turnover as the major problem reported by community residential facilities. In O'Connor and Sitkei's study (1975), it ranked second after inadequate funding.

Several attempts have been made to gather information on the roles and preparation of direct care staff. These primary caregivers perceive themselves as responsible for a number of "professional" functions (Humm

Delgado, 1979). They have not been given extensive training for assuming many of their responsibilities (Dellinger & Shope, 1978; Felsenthal & Scheerenber, 1978). Frequently on the job training is the primary mode of development. The need for providing more formalized training has been widely acknowledged (Fiorelli, 1980; Schinke & Wong, 1977). Several programs of prescribed credentialing and training have been proposed ranging from ongoing inservice programs to mandatory associate and college level training (Bank-Mikkelson, 1969; Fiorelli, 1979; Hollis, Tucker & Horner, 1978).

The professionalization of direct care services has been much more prevalent in staffed residential sites where personnel are in a clearly defined employee status. Programs utilizing foster parents, who have been traditionally viewed in a more voluntary status, have not received as much attention in the movement to improve direct care services. However, foster care services could benefit from more assertive programs of credentialing and preparation. Several studies have raised questions about the therapeutic merit of family foster care (Bjaanes & Butler, 1974; Seltzer & Seltzer, 1978).

The following sections further examine issues related to direct care service development in the family foster care model. Several aspects of family care provider development are given consideration.

Origins of Family Foster Care for the Retarded

Adams (1975) describes two separate systems from which the practice of alternative family placement for the mentally retarded have been developed. One, the institutional family care system, operated independent of the child welfare and social service fields for a number of years. Two, with the onset of reform in services for the mentally retarded, the child welfare field began to initiate programs of foster placement for retarded children, primarily to prevent institutionalization.

Alternative family placement for the mentally retarded is one of the oldest forms of deinstitutionalization and community service in the country. It was initiated in Massachusetts in 1885 (Foster Care Services for the Developmentally Disabled, Note 1) as part of the original plan of the institutional founders to return residents to live in the community after they had "graduated" from the institutional program.

> Originally, family care homes were conceived as extensions of the institution: a person who no longer required hospitalization, but who had neither the means nor the ability to live independently in the community, was placed in a family care home. There he could live out his years in a protective environment which was just as custodial as the institution, but considerably more pleasant. The individual continued to receive clothing, medical and dental treatment, and supervision from the institution, and he was not discharged. Through the years, the legislation and regulations governing the family care program

> have changed, but the basic structure of the program remains the same. (Ibid., p. 11)

This type of program received limited attention throughout the early phase of institutional growth and expansion. It was not until the 1930s and 1940s that the family care program became actively developed by several states as a point of exit from institutional care. The literature of this period reflects an optimism about the perceived benefits of family placement as an alternative to institutional care (Doll, 1940; Meyer, 1951; Vaux, 1935). Usually administered by the social service department of a large institution, these programs still continued to be closely affiliated with institutional care practices. Food, shelter and physical care were their primary functions with minimal attention to the educational and social benefits to be derived through community living.

California was one of the first states to transfer the administration of family care to an agency separate from the institution. In 1946 the Bureau of Social Work was given the responsibility for developing family care homes for residents who were discharged or placed on leave of absence from the institution. "This enabled the retardate to break from his identification as a hospital patient and make his assimilation into the community more effective" (Mamula, 1973, p. 25). This was the exception

to practice across the country. In Massachusetts, for example, the administration of family care remained a part of the institutional administrative structure until 1976.

In the early 1970s family foster care, particularly for prevention of institutionalization, became a popular approach to service for the retarded in the child welfare field. Greatly influenced by the President's Committee on Mental Retardation and other commissions for the study of children in America, the literature reflects the new enthusiasm of child welfare professionals for the utilization of foster care for retarded and other handicapped children (Coyne, 1978; DeVizia, 1974; Freeman, 1978). Garrett (1970) states:

> Foster family care has several advantages over institutional care for a child, especially one whose retardation stems from emotional deprivation or lack of stimulation rather than organic causes, for such functional retardates are likely to thrive in a normal family environment: (1) it does not set the child apart; (2) it provides social and emotional experiences through close, continuing relationships with parent substitutes; (3) it provides a greater chance for development along socially normal lines through day-to-day interaction with family and community; and (4) when the child is placed in his home community, it makes it easier for members of his own family to keep in touch with him. (p. 230)

Many of the recent developments in the practice of family care for the retarded, therefore, have resulted from a merging of the policy and practice of the social and child welfare fields with the movement for reform in services for the mentally retarded. Descriptive and

empirical literature from both these areas shed light on the complexities of implementing family care as a therapeutic residential milieu for both a handicapped and non-handicapped population.

The next sections of this chapter review relevant literature and research on the practice of foster family care for the retarded in order to provide a context for the current study. Selected literature related to traditional or generic foster care has been considered insofar as it contributes to a broader understanding of the family care foster parent role. Included in this review are: population receiving services; demographic characteristics of foster parents; roles; recruitment and selection; training methods; and identified needs for further research.

Population Receiving Services

The family care model has demonstrated a high degree of flexibility in terms of clientele. A group represented by a wide spectrum of age and disabilities have been deinstitutionalized or circumvented the institution entirely through family care home placement. A national survey carried out by the Developmental Disabilities Project on Residential Services and Community Adjustment has secured the most comprehensive information on the population with retardation residing in specially

licensed "foster" homes. From data on just under 2,000 homes surveyed across 32 states they developed the following summary of general resident characteristics:

> There are slightly more females than males in specially licensed foster homes. Of the residents, 69% are over 21 years old, 12.8% are younger than 15, and 19% are 15 to 21 years old. This repudiates the often held assumption that foster homes are for children.
>
> Information regarding residents' degree of retardation was obtained from the foster parents, or from the residents' social worker. One-third of all residents are considered either severely or profoundly retarded, 38% moderately retarded, 21% mildly retarded, and 8.1% borderline intelligence. This distribution parallels that of community residential facilities for mentally retarded people. (Bruininks, Hill & Thorsheim, 1980, pp. 23-25)

Family care providers are working with the same range of disability believed to require professionalized staff care in other residential sites. The information on physical and behavioral characteristics further identifies the types of handicapping conditions which are invariably influenced by the skill and attitude of the significant others in developmentally disabled persons' lives.

> . . . Fourteen percent could not talk, 4.9% were not toilet trained, and 4.1% were nonambulatory. These data are consistent with the priorities expressed by foster parents regarding their informal admission requirements. Although most foster parents apparently desire that residents have at least minimal self-help skills, 55% of the homes reported that they did accept severely or profoundly retarded residents.
>
> Behavior problems were reported for 9.7% of all residents. A significant proportion of residents had secondary handicaps, including deafness,

> blindness, epilepsy, cerebral palsy, or autistic traits. In addition to being mentally retarded, 8.6% of these residents had more than one secondary handicap. (Ibid., p. 25)

In addition to the developmental disabilities directly associated with retardation, a large portion of the population living in family care settings has been negatively affected by the socio-emotional deprivation of institutional living conditions. In a study of retarded persons released from institutions, Wyngaarden and Gollay (1976) report that 21% of the children and youth and 15% of the adults in their sample of deinstitutionalized individuals had been released to foster care. The emotional needs of clientele with a history of institutional care has been previously cited by foster parents and numerous others providing direct services as an extremely critical and complex factor in the adjustment of the client to community life (Justice, Bradley & O'Connor, 1971; Sternlicht, 1978). These clients also tend to need a great deal of remedial training in basic life skills not acquired in a custodial institutional setting. The ability to carry out appropriate forms of intervention for these types of needs is yet another area of expertise required for the successful provision of family care services.

Characteristics of Foster Parents

Carbino (1980) updates socio-economic information on foster parents as reported in the literature of the past ten years. She notes that although there is some variance by region and locality, data on foster parent characteristics are consistent in all sources she reviewed.

1. Foster parents tend to be in their middle to late forties, the usual age range being 26 to 64.

2. The average foster parent has not been educated beyond high school, although there is a wide range of educational levels from grade school through post college training.

3. Foster parents' occupations are generally blue collar, although both unskilled and managerial occupations are represented. Typically foster fathers are employed in skilled trades and foster mothers are homemakers or have unskilled positions.

4. Foster parents' incomes are in the low to middle range, with a noticeable proportion having low incomes.

5. Foster parents own their own homes and have low mobility compared to the general population.

6. The majority of foster parents are married and have children of their own. (pp. 3 & 4)

Data collected on specialized care providers seems consistent with this profile of generic foster parents. Nihira and Nihira (1975) report that of their sample of family care providers ". . . respondents were primarily female (91%), over 40 years of age (88%), married (77%),

Protestant (72%), with a high school or more education (67%)" and fell into either the middle or lower middle class economic strata (87%) (p. 10).

Mamula and Newman (1973) note that many of the specialized care providers in their program view family care as "an occupation based upon previous child-rearing expertise and enjoyment in raising children" (p. 29). Many foster mothers, having chosen foster care as an alternative to working out of the home, perceive foster parenting as a career. Many of them have had successful experience in generic foster care prior to involvement with children or adults with developmental disabilities (Rich, 1970).

Foster Parent Roles

A review of the literature reveals both a lack of clarity regarding foster parent role definition and confusion among foster parents and agency professionals regarding the foster parents' functions and responsibilities. Fanshel (1970) identifies several problems contributing to this ambiguity:

> (1) The child welfare field has failed to strengthen the career aspect of the foster parent role; it has remained a confused status position caught between being an altruistic enterprise and a paid job. It has been neither fish nor fowl.
>
> (2) . . . Agencies have used the services these people offer, but they have not permitted

> involvement of foster parents in the broader concerns of child welfare and specific family situations in which they are implicated. This paternalism shows in a most obnoxious form in settings in which the myth exists that foster parents are clients (p. 229).

Fanshel goes on to propose that the foster parent role should be viewed as a career with agencies developing modes of advancement and increased pay for experience and skill.

In a recent review of the literature, Carbino (1980) reports increased experimentation with the foster parent as a co-worker, paraprofessional, or agency employee. Freeman (1978) reports the positive aspects of such an approach in a program for the retarded.

> The biggest change within the agency is that the foster parents in this program are part of staff. They are no longer independent contractors providing service to the children of the agency; they are part of the total staff structure and programming. This is reflected in their being on salary, with deductions made and benefits accrued. The new status has changed drastically their orientation to the agency; they are much more involved, work closely with other staff, and are clear about agency resources they need to get their job done. . . .
>
> There are many demands on the foster parents' skill and time that agency staff never had to face in other foster home programs, and for the foster parent of the retarded to be effective, there must be more than the usual parenting gratification. The concept of professionalism, with a body of special knowledge, has brought strong positive response from the foster parents. (pp. 118-119)

It appears that the professionalism of foster parents counteracts a number of negative roles into which

they have fallen as reported in past foster care practice (Prosser, 1978). Adams (1975) suggests an additional angle on the value of professionalizing foster care for the retarded:

> . . . it is important that foster care for the more obviously retarded child has a strong visible professional image, to allay the reluctance natural parents may have about delegating their child's care to individuals rather than to an impersonal institution. Placement in the latter has been traditionally seen as an acceptable measure within the medical treatment model but foster care is not vested with equivalent professional status. (p. 277)

The image of the foster parent as a professional seems to have beneficial impact for the foster parents, the agency and the biological parents.

Recruitment, Selection and Evaluation

While recruitment of qualified foster parents in general has been a difficult problem in the child welfare field, attracting providers for a population with disabilities has presented an even greater challenge. The increased utilization of family care for the retarded and other "special" populations has intensified an already existing shortage of foster homes (Prosser, 1978).

Horejsi (1978) points out that part of the difficulty in recruitment is the sizeable responsibility and time commitment which family care providers are expected to assume. Given the traditionally inadequate payment

rates and the lack of recognition of the foster parent as a valued resource (viz. co-worker or paraprofessional), the incentive to foster parent is even further diminished.

> To maintain and retain foster homes, it probably will be necessary for agencies to move toward the concept of professional foster parents, including elements of a career ladder, respite care, paid vacations, special training and various supportive services. The professionalization of foster parenting provides additional rewards and enhances the image and status of foster parents. (Ibid., pp. 163-164)

Recruitment difficulties have had an immediate impact on the selection process. Kadushin (1974) comments:

> The shortage of homes limits the deliberate care with which the social worker can select a home . . . Despite the practice view that priority should be given the child's needs, in actuality not need, but resources available often determines decisions. (p. 457)

The method and process of selection have been further hampered by the lack of consistent data on the foster parent characteristics related to success, although considerable attention has been given this subject (Cautley & Aldridge, 1975; Fanshel, 1961; Sanderson & Crawley, 1978; Wolins, 1963) in regards to generic foster care. This research is frequently criticized for its inordinate focus on physical and social characteristics of foster families and too little attention to the personal, emotional and behavioral qualities related to successful performance (Prosser, 1978).

The burden of assessing and recommending applicants for foster parenting has been consistently placed on the shoulders of an individual agency worker, typically a social worker, who is usually functioning under tremendous pressure to produce foster homes. Under such pressure it is often difficult to maintain standards without specific criteria for judgement.

Ideally several interviews are carried out through home visits during which physical standards are checked out, the motivation of the family is explored, and the need and philosophy of the agency is explained. Under such a process it is difficult to measure much about the overall competency of the family or individual applicant. Wolins (1963) conducted a classic study of foster parent selection and found demonstrable evidence of how stereotype may influence the worker. Having elicited from workers their descriptions of "good" and "bad" foster homes, Wolins reports:

> The worker's projections revealed their image of the good foster family to be the Protestant ethic, substantially modified by Freudian psychology and nineteenth century humanism. Rationalism and planfulness are important in this family; so are fatherly bossiness and some motherly possessiveness. Both parents consider it reasonable to proceed in accordance with planned objectives that are not very different from the aspirations of their neighbors. . . (p. 97)

The predominant approach used in foster home assessment is based on a clinical model. Individual

interviews centering on family history, personal stability, family dynamics, and orientation to parenting are carried out and, based on information derived, the social worker, sometimes in conjunction with clinical supervision, is responsible for judging the appropriateness of the home. In light of the lack of empirical data on what constitutes competence in foster parents, and perhaps because of this, these practices are by in large considered acceptable in social work practice. Kraus (1971) comments:

> This lack of empiricism and objectivity in the approaches to foster home selection appeared to stem from the relatively common attitude among social workers that casework is an art, not a science. . . . The reluctance to modify the intuitive and judgemental approach to foster home selection persists despite its inefficacy, lack of validity, and the demonstrated superiority of statistical over clinical prediction. (pp. 63-64)

Although the process of selecting foster parents has suffered from the lack of empirical data, efforts to develop such data in the past ten years have been negligible (Carbino, 1980). Touliatos and Lindholm (1977) have developed a scale for use in foster parent selection. It has been developed around the standards of the Child Welfare League of America which do not have a research base. After reviewing this Potential for Foster Parenthood Scale (PFPS), Horejsi (1978) comments:

> One of the major weaknesses of the PFPS is that it requires the rater to form subjective judgements about the applicant. For example, the rater must

> just whether the applicant "can give love to meet a child's needs" (Item 28) and "would enjoy being a foster parent"(Item 37). There is always a danger that this type of rating and scoring procedure will result in a facade of precision or that the user will forget that the overall score is merely a summary of individual subjective judgements. In short, a scale of this design is only as good as the rater's ability to form accurate judgements. (p. 178)

One notable exception is the work of Cautley, Lichstein and Aldridge at the University of Wisconsin. Their work departs from previous research in two ways:

1. They go beyond the usual criterion on which "success" has been defined, i.e., continuation of a placement. They consider in their definition of success quality of care such as the foster parent effectiveness and skill in handling a child's major problems and sensitivity to the child's problems (Cautley & Aldridge, 1975).

2. Based on their research, they have developed a coded and numerically weighted instrument for use by social workers in assessing prospective foster parents. This instrument has been highly praised for its reduction of reliance on the social worker's subjective clinical judgement (Horejsi, 1978).

Their work, unfortunately, has thus far focused only on care for non-handicapped children from six to twelve years of age. Comparable research on "specialized" foster parents is not reported in the literature, although many theoretical suggestions regarding desirable specialized foster parent qualifications have been offered (Horejsi, 1978, Garrett, 1970). Mamula (1973), for example, offers a typical description:

Operators of community placement facilities for

> the mentally retarded--care providers--must possess qualities similar to individuals who provide care for normal individuals, but in addition they also need an unusual amount of patience, confidence, adaptability and tolerance. All care providers must have a stable marital status, be amenable to suggestion and willing to learn and grow, possess physical and emotional stamina, be able to love an individual as he is and possess the ability to work cooperatively with the placement agency. (p. 23)

Most emphasize personal qualities such as patience, adaptability, confidence, and so on, which are difficult to objectively assess and perpetuate the notion of the foster parent as a well-rounded, but unskilled volunteer. These characteristics are undisputedly important to the quality of a home placement, but they fail to reflect the true range of capabilities and personal characteristics associated with the successful provision of residential care. Begab (1970) elaborates more fully the demands for expertise on the part of foster parents for the retarded.

> Foster parents of the retarded need all the personal qualifications--understanding, warmth, consideration of others, emotional stability, security--that all foster parents require, plus some additional qualities. These special characteristics relate not only to the child's mental limitations and its concomitants, but to the wide range of behavior and needs these children present. For this reason, a single precise profile of the qualifications needed by foster parents of retarded children is unfeasible, though certain generalizations can be meaningful and practical. (p. 421)

While Begab and others have generally acknowledged the necessity for some unique capabilities in foster parents of the retarded, qualifications functionally related to

performance outcome have not been given indepth consideration.

Training and Development

The concept of training and development for foster parents, other than "on the job," is a fairly recent phenomena. "Even though the foster family care concept had its beginning in the U.S. in the 1800's . . . recognition of the special knowledge and skill needed to 'foster' a child has come about only recently. Educational programs for this type of program were even slower to develop" (Stone & Hunzeker, 1975, p. 1).

Throughout the late 1960's and early 1970's there was a noticeable increase in the training programs for foster parents. Stone and Hunzeger attribute this growth to several factors including: the emergence of foster parent associations; the need to resolve problems in the foster care system; the general population's acceptance of the concept of continuing and parent education; and the specialized foster care movement bringing with it the need for more indepth training in speciality areas.

Within the general foster care system, "training" has been interpreted in diverse ways. Informal discussion groups in which foster parents share questions and problems have been construed as training of a sort. More formalized training has ranged from compulsory agency

sponsored introductory sessions to intensive university courses (Prosser, 1978). Federal funds under Title XX have provided incentives to many states to develop foster parent training programs (Technical Assistance in Training Developmental Disabilities Personnel Project, Note 2; Northeast Conference, Child Welfare League of America, April, 1980).

Carbino (1980) cites several sources of information on training in generic foster care. These are not to be included in this review as they are numerous and only loosely related to the purpose of this study. Literature and research related to training for specialized family care providers is included in the remainder of this section.

Training for the provision of family care for a population with special needs has spearheaded much of the foster care training field. Training for this kind of foster care has been viewed as more critical to the population's needs and the success of placements. This can be seen in Gruber's (1978) recommendations after a study of the developmentally disabled in foster care in Massachusetts.

> It is recommended that specialized foster homes be those which employ professional foster parents . . . Compensation must be commensurate with time and effort. In addition, each professional foster parent must successfully complete a prescribed training program . . . The professional foster parent should also be required to participate in

> on going training programs and be required to complete periodic reports on their activities and changes in the children in their population. (p. 87)

Specialized family care has been distinguished from generic foster care as a vocation requiring more than experiential know how.

The literature has indicated some of the perceived training needs of specialized care providers. Nihira and Nihira (1975), using the critical incident technique, analyzed 194 incidents of positive or normalized behavior reported by 109 caretakers for mentally retarded children and adults.

> The results suggest that programs for caretakers' skill acquisition and behavior modification should become a vital ingredient to community placement programs. Several of the caretakers learned to break down daily tasks into bits of effort that their charges could learn quickly. Their training strategy came from their own youngsters enrolled in basic psychology courses. (p. 13)

Mamula (1974) reports that the use of training and structured training plans with foster parents of the retarded tends to increase the developmental gains of mentally retarded children in care and lessen the tendencies of caretakers to overprotect the child. Adams (1975), after reviewing literature related to foster care for "intellectually handicapped" children, draws similar conclusions.

Several curricula for training foster parents of the retarded have been developed (Murphy, 1975; Provencal

& Evans, 1977). In the late 1970's the Child Welfare League of America received a substantial federal grant to develop a training curriculum for foster parents of children with mental retardation. In carrying out field research of currently existing training, they canvassed over 900 agencies nationwide to "determine if they had a foster care program for retarded children; if they had a training program for foster parents of retarded children, or if they had any ideas about what was needed in a training program . . . " (Child Welfare League of America, Note 3, p. 19). Of the thirty agencies responding, the following major topic areas were identified in order of priority.

1. Identifying and using community resources, including ability to communicate with professionals.

2. Behavior modification/Behavior shaping.

3. Medical concerns related to giving injections and dispensing medication.

4. Developmental characteristics of the mentally retarded.

5. Teaching self-care skills.

6. Sexuality and the mentally retarded child.

7. Normalization.

8. Basic definitions of various disorders.

9. Administrative and management procedures required.

Other less frequently mentioned areas were:

1. Establishing appropriate expectations.

2. Developing communication skills.

3. Family roles in working with the mentally retarded child.

4. Recreation and leisure time activities.

5. On-going in home training.

6. Characteristics of institutionalized mentally retarded children.

7. Teaching social behavior.

8. Effects of separation on mentally retarded children (Ibid.)

Their research and development efforts resulted in the production of a basic curriculum entitled "Parenting with a Difference" (Foster Parent Curriculum Project, Note 4). The curriculum is a basic four session introductory course suggesting general approaches for successful foster care of retarded children. The aforementioned topic areas are covered to some extent in the curriculum. Of the curricula that have been developed, this is probably the most serious attempt to date to provide quality learning materials for foster parents of retarded children. Unfortunately it is an introductory ten hour curriculum which can only give cursory attention to a broad range of competency areas.

It does not appear that training has been implemented or researched to the extent that firm conclusions can be drawn about its content or value. It is universally recommended throughout the literature on foster care

for the retarded, but specifics about the most important subjects and most effective methods for training have yet to be defined through research.

Identified Areas for Further Research

The preceding sections reveal several definitive trends in the development of family care services for a population with mental retardation. Both generic and specialized foster care are experiencing a need to more clearly define the foster parent role. Greater experimentation with the concept of a professional or careerist foster care provider is suggested. This is seen as particularly relevant to specialized foster care where the distinct needs of the population receiving services have been recognized as benefiting greatly from direct care expertise.

A more purposeful definition of the family care provider role might improve upon previous practices of recruiting and selecting foster care providers. The literature depicts some fundamental weaknesses in procedures for evaluating and selecting foster parents. Many of these stem from the lack of predictive data on qualifications of foster parents related to success. The need for research on functional criteria for selection and evaluation is often cited.

As the competence of foster parents has been

accorded greater notice, efforts to train and develop foster parents have become more prevalent. A proven process for foster parent pre and in service development has not yet been designated. Training curricula content has usually lacked an empirical basis. Research needs to be undertaken which can be applied to planning training and development activities.

A consistent theme through the literature is the need for improved systems of cultivating the human resources providing family care services. This is increasingly evident in the implementation of specialized family care programs.

The remainder of this chapter considers an approach which has potential application in the resolution of some of these needs. Competency based systems and particularly the process of competency specification are investigated.

Competency-based Education, Training and Career Development

A competency-based movement, particularly in the field of education, has attracted widespread attention in recent years. The development of competency-oriented education has been the subject of dialogue and debate in the academic community since the late 1960's. As noted in the preceding chapter, the principles of the competency-based

movement have been applied in a number of state licensing and credentialing systems.

The initial impetus for competency-based education (CBE), also referred to as performance-based education (PBE), is generally attributed to two areas of need in the field of education. The first is an emphasis on accountability. The educational community has been pressed to demonstrate its effectiveness in a quantifiable way. Society has been demanding higher guarantees that education at any level is doing its job. "Students want to know that what they are learning will increase their capabilities for quality performance and satisfaction in the world of work. Teachers want to demonstrate that they are having significant and measurable effects on student learning . . . All want to know what should be taught and what in fact is being learned." (Pottinger, 1977a, p. 35).

Hand in hand with the impetus for developing accountability has been the mounting demand of the public for demonstrable cost-effectiveness in education and other human service fields. "With increasing budgets and restricted funds, society is pressing educators to relate systems input (dollars, personnel, buildings, resources) to systems output (increased student or consumer achievement related to goals of society)" (Houston, 1974, p. 6). Thus both programmatic and fiscal accountability have been

two key factors underlying the rapid evolution of the competency-based movement.

The roots of competency-based concepts can be traced to training and behavioral psychology (McDonald, 1974), much of which has been applied to personnel and human resource research in industrial and military settings. Both of thse fields have had a much greater commitment to the study of manpower utilization and performance than has past been seen in education and related human services. Influenced by a more utilitarian and cost-effective philosophy of human resource management, industrial and military personnel and training departments have developed a variety of job analysis, job performance and job classification systems which have provided what is believed to be a more efficient framework for recruitment, hiring, placement, training and promotion of personnel as well as general organizational development. These systems emphasize the relationship between job tasks, job performance, and organizational goals. Training and other forms of employee development are always designed to improve a specific aspect of job performance which is related to the overall needs of a particular organization (DeCotiis & Morano, 1977; Morano, 1973).

The U.S. Employment Service of the U.S. Department of Labor has been instrumental in supporting research on job classification and performance since the 1933 mandate

of the Wagner-Peyser Act to classify jobs so that workers could be placed in work suitable to their potential. "While the Act realized a dream of the vocational guidance movement for official government support for the concept of 'matching men and jobs,' the tools and methods for effecting this concept were few and imperfect. What this concept needed for the matching to take place was the formulation of qualifications of workers and the requirements of jobs in the same terms so that the measures of the one could be equated with the other" (Fine, Holt & Hutchinson, 1975, p. 1).

What resulted from this need was a large body of job analysis and worker performance research which focused on defining job tasks in terms of worker behaviors and outcomes. "Understanding of the behavior led back beyond the worker's instrumental functioning to his adaptive skills, his uniqueness as a person. Similarly, understanding of the outcome led back to the objectives, goals, purposes, needs, and values of each specific work organization" (Ibid., p. 2).

The competency-based movement parallels this interrelationship between organizational goals, job tasks and worker qualifications. Competency-based teacher preparation, for example, is concerned with the school's organizational goal of maximizing student learning through competent teacher performance. Teaching or the perfor-

mance of teaching tasks (worker behavior) is believed to be directly related to identifiable and measurable teaching skills (worker qualifications).

From a competency-based perspective, the effective teacher preparation program would be one which: defines the competencies related to successful performance as a teacher; makes explicit the criteria to be used in assessing the teacher trainee's competencies; and, holds the teacher trainee accountable for meeting those criteria based on individual learning style. The competencies referred to would be understandings, skills and behaviors that facilitate intellectual, emotional and physical growth in children.

Defining Competency-based Systems

A universally accepted definition of the "competency-based" or "performance-based" movement has not yet been established. The definitions which have been offered primarily reflect the competency-based educational movement.

Richmond and Nagel (1972) assert that "competency-based programs are those programs in which the competencies (skills, behavior, fitness) to be acquired by the student and the criteria to assess the student are made explicit and the student is held accountable for meeting those criteria" (p. 59). Hertling (1974) describes some

essential elements of competency-based education:

> Competency-based education assumes that the competencies required for successful performance in a specific role or occupation can be identified and that an education program can be conceived which will enable the participants to develop these competencies. Rather than awarding a certificate or degree on the basis of the number of courses taken or credit huurs accumulated, satisfactory completion is based upon the demonstration of specific behaviors thought to be associated with success in a particular occupation. Students are held accountable for attaining an acceptable level of competence. They are evaluated on the basis of what they can do rather than upon what they know or say they will do when faced with the need to perform a specific task. All teaching and learning activities are related to the development of specific competencies, and anything not related to the achievement of these objectives has no valid claim for inclusion in a CBE program. (p. 50)

Parady and Eisele (1972) contrast competency-based education systems with theory-based education as follows:

> Competency, of course, is the important concept, the sina non quo of CBE. The learner will have X number of reading skills, he will differentiate among geometric forms with Y percent accuracy, he will know Z number of economic concepts and so on. This is different from the usual approach of saying: Given X amount of time, we will teach the learner to the best of his and our ability. In this latter approach, time is the major limiting factor, in CBE, time is said to be basically inconsequential. (p. 545)

There seems to be a minimal difference between the meaning of competency-based and performance-based systems. The terms are generally used interchangeably. Performance- based has been distinguished from competency-based in its greater emphasis on demonstration of skills

and knowledges through overt action. In contrast, competency-based terminology stresses the notion of a minimum standard for effective performance (Hollingsworth, 1974; Houston, 1974).

Besides the application of the competency-based concept to academic and training programs, its utility in general personnel development systems has been recognized (McLelland & Boyatsis, 1980; Klemp, Note 5). The competence assessment movement, so named by David McLelland and his colleagues at McBer & Company, a Boston based personnel consulting firm, has been popularly publicized as an alternative to traditional approaches of employee selection, performance evaluation and development (Goleman, 1981; Klemp, Note 5; Pottinger, 1977a). As in academia, no universally accepted definition of competency-based manpower development has been established. The primary elements of competency-based manpower development parallel those of competency-based education. Competencies necessary for effective performance are identified and clearly defined, measures for assessing these competencies are developed and, based on this established criteria for competence in a given job, selection procedures, career development strategies or assessment techniques are designed (Klemp, Note 5). Unlike traditional personnel development systems, the competency-based model emphasizes precision in measuring

potential or actual work performance in prospective or incumbent employees for a particular job. "No one can dispute that it makes more sense to design a test around the specific abilities and psychological qualities required in a job than to select people who perform well in tests of general aptitude" (Goleman, 1981, p. 46).

Competency-based education and personnel development systems are therefore closely aligned with job performance criteria. They have the qualities of making explicit the requirements for effective performance, for making these requirements public and for holding the individual, whether employee or student, accountable for demonstrating those requirements. Modes of instruction or methods for attaining the performance outcomes are flexible with an emphasis on individual style.

Methods of defining competence. What seems to have generated some controversy in the development of the competency-based movement has been the issue of how competence is defined and identified (Klemp, 1979; Pottinger, 1977a). In reference to competency-based education, Klingstedt (1972) states that it "is based on the specification or definition of what constitutes competency in a given field. Usually a great deal of research is considered, when available, before competency levels are identified" (p. 10).

Given the pivotal relationship between competency specification and the validity of competency-based systems, it is somewhat ironic that there has been marked inconsistency in definitions and approaches to defining competence. Butler, F. (1978) relays the reasons for this disharmony:

> . . . But, whenever the topic [competency-based education] is discussed, there is almost always an immediate and universal lack of agreement among educators as to what constitutes competence and how to describe it. Among supporters and skeptics alike, presumptions about competence-based programs are confused because of the many different views concerning the meaning of the word competence itself. To some, competence is seen as the application of knowledge; to others, it is knowledge and skill combined; still others maintain that knowledge and skills constitute separate competences. Some equate competences with behavioral objectives, others see competences as more global and general in concept . . . With these and other fundamental disagreements, it is understandable that there is a wide range of opinion about the form and merits of competence-based education. (p. 7)

Klemp (1979) suggests that the origins of some of this confusion is attributable to a cultural emphasis on knowledge.

> Historically competence at a job was first determined by a person's ability to perform the required tasks at an acceptable standard. Apprenticeships existed in which a student worked with a professional until some criterion of performance was achieved. Gradually, however, competence began to be attributed on the basis of how much a person knew; thus knowledge of business, science or literature was taken as an indication of a person's ability as a manager, chemist, or writer . . . Competence has been taken to mean knowing how to perform or possessing the aptitude for performance, rather than demonstrating that

> knowledge or attitude. Knowing has been distinguished from doing. Many who would measure competence, therefore, find themselves inferring the ability to do from knowledge, rather than the other way around. (p. 42)

Klemp goes on to emphasize the importance of considering both knowledge (content) and use (process) competencies. He defines competency as a generic knowledge, skill, trait, self-schema or motive of a person that is causally related to effective behavior referenced to external performance criteria, where:

> Knowledge is a set of usable information organized around a specific content area (for example, knowledge of mathematics).
>
> Skill is the ability to demonstrate a set of related behaviors or processes (for example, logical thinking).
>
> Trait is a disposition or characteristic way of responding to an equivalent set of stimula (for example, initiative).
>
> Self-schema is a person's image of himself or herself and his or her evaluation of that image (for example, self-image as a professional).
>
> Motive is a recurrent concern for a goal state or condition which drives, selects, and directs behavior of the individual (for example, the need for efficacy). (p. 42)

According to Klemp's definition, and supported by several other leaders in the competency movement (Butler, 1978; McLelland & Boyatsis, 1980; Pottinger, 1977a), competency and behavior or performance are closely linked, but the two are not equivalent. Competencies are viewed as variable, sometimes observable, but often more subtle,

which are causally related to certain behavioral outcomes.

This emphasis on a causal relationship between competency and performance necessitates that much greater attention be given to performance criteria in the specification of cmpetencies. Indeed, one of the frequently cited criticisms of many competency-based programs has been the apparent lack of vigor applied to competency specification (Broudy, Drummond, Howsam & Rosner, 1974; Pottinger, 1977a; Tarr, 1974).

In the next section, several of the most common methods of competency specification are briefly summarized and reviewed. Also reviewed are some less common, but more analytical methods. The Job Element Analysis process chosen for the present study is included in this review.

Competency specification. As objective as the competency-based movement claims to be, the practice of prescribing what makes an individual perform competently in a given occupation has been fairly subjective. A review of several articles on competency-based teacher preparation found the use of fairly imprecise procedures for defining competencies of a special education curriculum. In many programs, literature reviews have been the single method of specification (Bullock, Dykes, Kelly, 1974; Edgar and Neel, 1976). In some others the literature combined with the opinions of experts, usually university faculty, have

been the empirical base on which the competency-based curriculum has been derived (Strauch & Affleck, 1976).

These methods of defining proficiency in an occupation are subject to weakness in validity and reliability. Pottinger (1977a) asserts that the "most popular yet inadequate technique for defining competence is the sole judgement of experts . . . the empirical evidence is overwhelming that the phenomena of selective perception, beliefs and value systems contaminate objectivity so as to make expert judgements unacceptable" (pp. 35-36).

Many programs which have attempted to incorporate greater objectivity into their process have applied principles of task analysis, goal analysis and job analysis for the purpose of deriving competencies (Andrews, 1974; Austin, 1979; Hollingsworth, 1974; Mehr, 1977). The desired outcome of these approaches is the identification of competencies relevant to job tasks and thus job performance. "Job analysis may be defined as any process of collecting, ordering and evaluating work or worker related information. It is not an end in itself but rather a means to any of several ends" (Wilson, 1974).

Job analysis. As discussed earlier in this section, a considerable amount of research has been conducted by the U.S. Department of Labor and other governmental agencies as part of an effort to improve manpower

planning and development (U.S. Civil Service Commission, 1973). A wide range of job analysis techniques is now available for use (Wilson, 1974). These employ various modes of dissecting a job's functions including checklists, questionnaires, observations, individual or group interviews and logbooks. Whatever the process used, the end result should be a description of the duties of the job "in sufficient detail that it can be used for determining the abilities, skills, knowledges and/or other worker characteristics required to perform the job" (Plumlee, 1976, p. 2).

One of the most widely researched and published job analysis techniques, Functional Job Analysis, was developed by Fine and Wiley (1971). This classical approach includes the key components of a typical job analysis process.

Functional Job Analysis essentially looks at what workers do, or worker behavior, and what gets done, or end results (Fine & Wiley, 1971). The analysis results in a list of task statements which "are verbal formulations of activities that make it possible to describe what workers do and what gets done . . . "(Fine, Holt & Hutchinson, 1974, p. 4). Task statements are presented in behavioral and measurable terms so as to reduce ambiguity about the worker functions. These are usually reviewed and edited by an organizational membership. By dissecting the func-

tions of a job in terms of its job tasks, decisions can then be made about performance standards and skill requirements for the execution of each task statement and cumulatively for the total job.

Functional Job Analysis and other similar forms of job analysis typically result in taxonomies of skills connected with particular kinds of jobs. These in turn become the base data on which a competency-based curriculum or credentialing system is built. There are several criticisms of this approach to competency specification.

> --A complete job task analysis is much too detailed to be practical. For example, there are over four hundred discrete behaviors that can be listed for the ability to drive a car. Such a "laundry list" gives us all the detail for which we could ask, but no information about how all these behaviors work together in actually performing a complex task on the job.
> --Job task analyses are not selective. Of all the tasks identified for the performance of a job, roughly 80 percent turn out not to distinguish successful from average performance. The remainder do make a distinction, but there is no way to differentiate them using task analysis procedures.
> --The focus of job task analysis is on the job, not the person who performs the job. While we can identify particular knowledges and skills that go with job tasks and measure a person in performance of those skills, we can only guarantee that a person can do parts of the job, not whether he or she will do the whole job or produce quality work. (Klemp, Note 5, pp. 5-6)

Pottinger and Klemp (1976) summarize the criticisms as follows:

> The job function analysis approach is based primarily on motor skills analysis and has utility in their identification, but it is too narrow an

> approach to be used as a method for determining significant dimensions of job competence. This approach, sometimes carried to the extreme, results in taxonomies of hundreds, sometimes thousands of motor skills connected with particular kinds of jobs . . . While job function analysis may help one understand common job elements for setting equitable pay scales, it does not differentiate which aspects of the job are most important to success, nor does it identify critical or differentiating characteristics of the job performer. (p. 45)

Pottinger and Klemp go on to describe the following alternatives to this approach which address some of these concerns.

Critical incident technique. This procedure, developed by Flanagan in the 1950's, looks at job behavior in terms of critical instances of either outstanding or poor "on the job" performance.

> To be critical, an incident must occur in a situation where the purpose or intent of the act seems fairly clear to the observer and where its consequences are sufficiently definite to leave little doubt concerning its effects. (Flanagan, 1954, p. 327)

Supervisors record their observations or recall of such incidents over a period of time. Specific information about each incident is elicited, including what led up to each incident, exactly what happened, and why the described incident was considered such a help or hindrance. These incidents are then analyzed to determine the critical performance requirements of the position under study. Applications of this procedure have been extensively used for a variety of manpower development

needs, including training, selection and classification, job design and purification, counseling and performance measurement (Ibid.).

This technique goes a step beyond the pure task orientation approach in that it attempts to specify job behaviors in terms of positive and negative impact on performance and to avoid long listings of insignificant worker behaviors. However, it is a fairly clinical approach, relying very much on subjective opinion in the identification, analysis and classification of the incidents without substantial empirical evidence of the accuracy of predictions made from the data analysis.

Job element analysis. Ernest Primoff's Job Element Analysis has been described as a more systematic variation of the critical incident technique (Pottinger & Klemp, 1976). Primoff (1975) states that "the major goals of research on the job element procedure have been (1) Representing the major structure of worker superiority on the job, and (2) Rating people accurately" (p. 2).

In conducting a Job Element study a panel of experts on the job is first convened to suggest a tentative list of "job elements." Job elements are defined as those worker characteristics which influence success in the job, including combinations of abilities, skills, knowledges or personal characteristics. After an exhaustive list is generated, the panel members rate each

individual element based on a rating system that considers:

--its practicality in terms of entry-level requirements,

--its reliability in distinguishing "barely acceptable" from "superior" work, and

--the trouble likely to be caused if it is not considered.

These ratings are then analyzed via formulas researched by Primoff for validity and reliability. The formula computations result in a designation of which elements make the largest contribution to success on the job, which elements should be acquired prior to hiring, and which elements are highly suitable for training efforts. This list serves as a set of hypotheses about the critical worker characterists for the job under study. It can be used to develop a crediting plan for job applicants, a performance evaluation plan for job incumbents, training programs and other instruments of manpower development.

The obvious benefit of Job Element Analysis, as opposed to job task analysis, is its focus on worker characteristics which distinguish superior from average work performance. Because of its emphasis on superior performance, it results in a more discriminating listing of worker characteristics or competencies which make a significant difference to performance on the job. In addition, the procedure identifies attitudes, interest and

other personal characteristics which are not given consideration in traditional job analysis processes.

In reviewing the application of this technique for competency identification, Klemp and Pottinger (1976) suggest a further measure of validating hypothesized worker characteristics through self and supervisory ratings of groups of both average and superior job incumbents. This procedure generates additional data which can be used to determine the relative significance of each element in distinghishing average from superior performers.

A weakness of Job Element Analysis is its reliance on expert judgements, resulting in the possibility that the perceptual bias of panel members in the form of beliefs and values may influence the process. Primoff (1975) acknowledges this drawback and proposes that this bias is best held in check by a continued review of the reliability and validity when applying information derived through the process.

Behavioral event analysis. David McLelland (McLelland & Boyatsis, 1980) has developed a technique which appears to have combined the more salient principles of Job Element Analysis and the Critical Incident Technique with the use of a structured interview technique. In Behavioral Event Analysis, exemplary and average job performers are identified through objective

outcomes (e.g., profits, sales, etc.) and/or subjective ratings (e.g., peer, supervisor). Using the panel and rating procedures prescribed for Job Element Analysis, hypotheses about competence are developed. Structured interviews are then conducted in which detailed accounts of critical work incidents are elicited from the workers. It is believed that through these interviews the more subtle and nonobservable worker characteristics relating to success, such as thoughts or attitudes, can be better identified. "In other words, this interview procedure elicits information from which actual overt and covert behaviors can be reconstructed, rather than eliciting interpretations or perceptually biased recollections of past behaviors" (Pottinger, 1977a, p. 3).

When the data from the interviews is coded and analyzed, equal consideration is given to the covert and overt behaviors described and to the differences between these for superior and average performers. In their research to date, McLelland and his associates have found a surprisingly high relationship between the latent or nonobservable characteristics and the superiority of performance (Goleman, 1981).

From this they have theorized that though many observable and covert behaviors may be shown to be statistically associated with competence, they may not necessarily be the actual cause of competence. They

suggest the need to define aspects of competence which are both statistically and causally related to superior performance, many of which may be the less obvious attitudes and feelings of the worker.

Behavioral Event Analysis and the theory underlying its application have no doubt greatly broadened the possibilities for improving competency based systems through the production of increasingly relevant information on worker characteristics in the work world. While it involves much greater technical expertise on the part of program developers, as well as considerable financial expenditure, it offers a more rigorous and meaningful approach to competency assessment. It is important to also note that the results of this process are too recent for meaningful evaluation of its effectiveness (Goleman, 1981).

Summary

The intent of this chapter has been to provide a context for viewing the present study. The impact of reform on residential services for the mentally retarded has been reviewed. The role of direct care services in the implementation of reform in residential service delivery has been explored, leading to a conclusion that the "professional" functioning of direct care staff plays an important part in the provision of non-custodial residen-

tial care. The need for further examination of direct care service provision in the family care model has been identified.

An overview of family care for the mentally retarded has been provided. Literature and research on foster parent roles, recruitment, selection and development have been reviewed. The need for improved approaches has been established and the development of a competency based approach has been proposed.

The final section of the chapter has been devoted to a review and discussion of competency based systems. Origins, definitions and issues related to the development of competency based programs have been examined. The chapter has concluded with a review of approaches to competency specification.

C H A P T E R I I I

OVERVIEW OF THE MASSACHUSETTS SPECIALIZED HOME CARE PROJECT

Background

As discussed in Chapter two, the concept of placing persons out of institutional settings into family-based settings is one of the oldest forms of deinstitutionalization in the country. In Massachusetts, family care placement programs were operated by the state's institutional facilities since the 1800's. These programs, originally conceived as extensions of the institutional care system, were administered by the social service departments of individual state schools for the retarded. In March, 1973, 108 family care placements were accounted for by the Department of Mental Health's six major institutions for the mentally retarded.

By the early 1970's, the state's Department of Public Welfare was also serving a significant number of disabled children within its foster care system. Gruber (1978) reports that ". . . almost 40% of the children placed in foster home care in Massachusetts, in 1971, were handicapped in some way other than the fact of their foster child status" (p. 76). Of this group, there is no

exact estimate of the number who had a primary disability of mental retardation although a follow-up study of a sample of the handicapped population in care revealed that 17.5% were reported by foster parents to have mental retardation and 25.6% to have moderate to severe learning problems.

In the early 1970's studies and investigations of the Department of Mental Health's family care program and the Department of Public Welfare's foster care program revealed serious inadequacies in the operation of both these systems (Gruber, 1973; Gruber, 1974; Foster Care Services for the Developmentally Disabled, Note 1). In 1976 these recommendations were acted upon in the form of a Department of Mental Health sponsored statewide program named the Specialized Home Care Project. Administration of the Project was transferred, through contractual arrangements, to private agencies throughout the Commonwealth. The roles and expectations of the individual family care sponsors were considerably modified, as was the funding and monitoring of the program.

Philosophy of Specialized Home Care

The philosophical basis of Specialized Home Care has been stated by the Department of Mental Health as follows:

The Specialized Home Care concept is based on the

> principle of normalization, a programmatic philosophy endorsed by the Department, which calls for making available to mentally retarded individuals those patterns and conditions of everyday living which most nearly approximate the regular circumstances and ways of life of non-handicapped members of their society.
>
> By offering each client a full range of residential, educational, vocational, support and respite services, the Specialized Home Care Program maximizes the client's participation in the community and thereby allows the client to experience life as others do. (Hill & Feinman, Note 6, p. 1)

The program has become viewed as a bonefied community placement alternative for mentally retarded children and adults. It is considered to have the benefits of community integration through placement in private homes and individualization through limiting the number of placements at each home site.

Program structure. Specialized Home Care was initially developed solely on a foster care model, allowing for placement of from one to three clients in each participant (Care Provider) home. Within the first two years of its existence, some modifications for use of Specialized Home Care funds were made to accomodate a reported need for service diversity in the Department of Mental Health's community service network. Thus, the program has expanded to include a staffed apartment model and a model of support services to biological families.

This chapter is limited to a discussion of the

foster care model. This has been the primary model implemented statewide (Specialized Home Care, Program Analysis and Description, Note 7) and is the only model on which the present study is based.

Administrative structure. Specialized Home Care is administered by the Department of Mental Health, through contractual arrangements with private agencies. The Department of Mental Health establishes policies and guidelines defining operational requirements for the Project. This provides for a consistency in program implementation. Private agencies, with the assistance of Department of Mental Health local offices, are responsible for analysis and interpretation of the policies and have some degree of flexibility in execution of the program.

Specialized Home Care follows a Department of Mental Health management structure based on a geographic regional and area system. The geographic boundaries of the seven regions are identified in Appendix A.

Vendor responsibilities. The vendor or private agencies contracted to develop Specialized Home Care services are responsible for establishing programs of recruitment, selection and training of the Care Providers into whose homes the clients are placed. They screen client referrals for placement, coordinate placements and client services, and supervise and monitor placements (Hill & Feinman, Note 6).

Services for clients. The basic process--placement of clients in private home settings--necessitates the utilization of services external to the residential site for vocational, recreational, medical and other needs. Assistance and advocacy on behalf of the client in arranging these services is provided by the Care Provider in conjunction with the client's assigned staff worker. Services to the client's biological family or guardian including arrangements for visitation, periodic progress reports and, less frequently, counselling are provided by Specialized Home Care staff.

Within the residential site itself is the provision of food, shelter, and varying levels of supervision depending upon client capabilities and development. Clients also receive the benefits of "developmental training" from the Care Provider in areas which will enhance home and community living skills. Training also varies depending upon individual client developmental stages. For some of the persons in placement who are preparing for transition to a more independent living situation, training might be focused on developing banking, money management, cooking and housekeeping skills. For persons with more extreme developmental delays, the training is applied toward increasing and refining basic daily living skills such as toileting, dressing, toothbrushing, eating, etc. For children, who

are of varying developmental levels, training is directed toward the acquisition of age level skills.

Developmental training services are considered a major difference between Specialized Home Care and generic foster care. Formal training plans, having many similarities to the Individual Education Plans (P.L. 94-142) prescribed for students with special needs in a school setting, are designed for each client. These identify goals, objectives and educational strategies to be used by the Care Provider. The inclusion of this type of structured training system expedites monitoring of client development and evaluation of the habilitative capacity of the Care Provider and home environment.

The addition of developmental training has also greatly diversified the Care Provider role from a more passive to an active status in the client's habilitation program. Care Provider responsibilities identified in a later section reflect this change in status.

Staff responsibilities. The basic program functions are executed through a variety of staffing patterns developed by individual agencies (Specialized Home Care, Program Analysis and Description, Note 7). Generally the administrative functions of overseeing fiscal, programmatic and licensing issues are assumed by a Regional Director. Recruitment, selection and home evaluation of Care

Providers is usually provided by a field based staff, although in some cases the staff is housed within the central offices of sponsoring agency offices. These staff (Placement Coordinators, Area Managers, Social Workers, etc.) are also responsible for the overall functions of client screening, pre-placement planning and client service coordination after placement.

Several programs have streamlined these functional responsibilities of staff by creating staff positions which are solely responsible for Care Provider recruitment, homefinding and orientation activities across a whole regional area, thus freeing up the time of field based staff for supervision of homes and support of client placements. Likewise, Care Provider education and training, though in some cases the responsibility of field based staff, has more frequently been assigned to a regional staff person with a background in training.

Care Provider responsibilities. One of the major differences between Specialized Home Care and the former family care model is the increased responsibility designated to Care Providers. The Care Provider is responsible for:

- providing care, supervision and training to the client in accordance with the service plan;
- assisting the client in utilizing community services;

- participating in the evaluation of the client and the development of the service plan;
- periodically reviewing and documenting the progress of the client;
- providing transportation for routine medical appointments, dental appointments, etc.;
- attending Individual Education Plan meetings, and Individual Service Plan meetings;
- keeping programmatic and financial records of client training, activities and funds. (Hill & Feinman, 1980, pp. 3-4)

Care Providers are responsible for the day to day supervision of client developmental, emotional and medical needs. "Because the provider is involved in the training, not just the care of the client, providers are considered as paraprofessionals, as members of the service team" (Media Resource Center, Note 8). The intention of assigning this status to Care Providers has been to improve the habilitative qualities of this residential model. In such capacity, Care Providers are the primary implementors of programmatic activities formerly lacking within this model of residential care. Care Providers are not salaried staff, but they do receive payment for assuming these additional responsibilities.

Payments to Care Providers. In addition to receiving $6.00 per day from the client for room and board, Care Providers are reimbursed by Specialized Home Care for their in-home developmental training services.

Developmental training payments range from one to five hours per day at the federal minimum wage rate. Thus, payment for client placement could range from $9.35 to $22.75 per day.

Care Provider selection. The vehicle for selecting Care Providers is a formal home study process following the format of typical foster parent selection procedures described in Chapter Two.

> This evaluation is to be a mutually exploratory process whereby the care provider as well as the staff carefully examine the responsibilities of the SHC (Specialized Home Care) program and the provider's ability to be responsive to the client's social, intellectual and physical needs.
>
> The home study evaluation process includes:
>
> - planned interviews between home study evaluation staff and the prospective care provider
> - evaluation of physical facilities
> - examination of written documentation, including health records, interview results, plans for supervision of the home, board of probation clearances
> - review of references provided by applicant, to supplement information obtained by interviews with and observations of the care provider. (Hill & Feinman, Note 6, p. 30)

The field based staff who carry out this evaluation have been given general guidelines from the state about criteria to be considered in assessing applicant Care Providers, but the actual specifications for Care Provider eligibility and acceptance are tailored by the policy and practice of the administering private agency.

Care Provider Education and Training. Training is mandatory for all Care Providers, both prior to and after approval. The state has stipulated in its guidelines that this be a "comprehensive training program" which includes twelve to eighteen hours of preservice training and an equivalent amount of inservice training throughout every year after approval.

Care Providers sign a formal education agreement at the time of approval which outlines requirements for training and disciplinary measures in case of failure to honor the agreement. A serious and unresolved breach of agreement can lead to termination of the Care Provider.

The content and structure of Care Provider training has varied widely from region to region. Curricula and training content are not coordinated at any state level. Minimum competency requirements not having been established, private agencies frequently rely on local judgement and informal needs assessments to determine training needs.

A general concern expressed by administering agencies has been the difficulty in choosing from a broad range of possible topics including practical issues such as fire safety or first aid and theoretical areas such as normalization or sexuality. Principles of behavior management and learning are also considered important to the Care Provider role.

Of equal complexity has been the problem of addressing a wide range of Care Provider education and experience. Some Care Providers have never had experience or even exposure to a population with mental retardation while others have professional backgrounds and credentials in the field. Mandatory training requirements for some of the Care Providers bringing experience to the job can be waived, but a process for determining how or when training should be waived has not been designed. Since formal evaluation of Care Provider education and training programs has not occurred to date, it has been difficult for administering agencies to make informed decisions regarding modifications and development of an ongoing training and development system.

Monitoring and supervision of the Care Provider. Individual supervision of the Care Provider is implemented by the field based staff, who have contact with Care Providers on at least a monthly basis. Supervision centers on the adjustment and development of the client(s) in placement and on other areas specific to client growth. Client training is also reviewed and modified as necessary.

Each Care Provider is formally evaluated on an annual basis. No formal evaluation instrument exists, but general areas of strength and areas for growth are iden-

tified in writing by the supervising staff person and shared with the Care Provider.

Summary

The intent of this Chapter has been to present an overview of basic philosophy, policies and procedures specific to the Massachusetts Specialized Home Care Project. The background leading to the development of this program illustrates the need for measures of quality assurance when utilizing the foster care model for individuals with handicaps. The stated philosophy and goals of Specialized Home Care reflect a response to this need with a strong emphasis on normalization and community integration of persons with mental retardation.

The administration of the program has been designed around a private agency structure with the Department of Mental Health assuming a support and monitoring contractual role. Overall vendor and staff functions have been consistent across agencies, but staff responsibilities have been carried out through variegated staffing patterns within each region.

Care Providers have been given notable authority and responsibility for the on-going provision of service. Their role within this residential service model has been considerably broadened. Responsibility for the provision of on-going developmental training is a major addition to

the Care Provider duties.

Guidelines for selection, supervision and mandatory training of Care Providers place an emphasis on the development of Care Providers who have the capacity to assume many professional responsibilities. However, structured processes and systems for enrichment of Care Providers are still in the formative stages of development.

C H A P T E R I V

DESCRIPTION OF METHODOLOGY

Introduction

This chapter delineates the methodology of the current study. It begins with a brief rationale for the choice of the Job Element Analysis methodology and a description of participant determination and research clearances. This is followed by a description of the two major phases of data collection. Phase One involves the procedures carried out to derive the data base on which the questionnaire, administered in Phase Two, is constructed. Information on sample composition and statistical analysis is presented separately for each phase.

Rationale for the Use of Job Element Analysis

Job Element Analysis, as described in Chapter Two, was the chosen methodology for the present study. Job Element Analysis was developed by Ernest Primoff and procedures for its execution are described in Primoff's 1975 publication, How to Prepare and Conduct Job Element Examinations. This system of job analysis had several characteristics which made it highly suitable for application in the present study. Probably most significant to

the choice of Job Element Analysis was the fact that it has been extensively researched over a number of years by the U.S. Civil Service Commission and has been previously used in the study of human service positions (Spivey, 1976; Spivey & Goulding, 1976). Other aspects of Job Element Analysis which contributed to its selection are as follows:

1. Persons conducting job element studies do not themselves identify elements and sub-elements of the job or make decisions concerning the content of the job. Since the author is currently directing one of the programs from which the study population was drawn, it was considered important that there be control for subjectivity or bias which might influence the results of the study.

2. This procedure identifies worker characteristics or competencies which are related to superior performance rather than merely average or typical performance. This emphasis on the outstanding care provider was considered compatible with the goal of developing a high performance standard. Of equal consideration were the benefits to be derived by limiting the competency listings only to the most relevant performance areas. It was believed that such a refined listing would be more palatable to persons considering future application of the data.

3. This procedure includes job incumbents and supervisors of job incumbents as opposed to outside analysts or observers. This allows for a high sensitivity to the realities of the job and limitations imposed by outside forces. It was hoped that inclusion of agency employees in the process would create a greater receptiveness to future application of the information generated.

4. This procedure is highly cost efficient. This was pertinent not only to the present study but to the field of human services which has historically bypassed employee development activities based on budgetary constraints.

It should be noted that in addition to the Job Element Analysis procedure, as developed by Primoff, a Care Provider Questionnaire and a Supervisory Questionnaire were designed and administered to Care Providers and their supervisors in the final phase of the study. As discussed in Chapter Two, this particular procedure has been recommended as an additional measure for assuring field-based input on the merit of competencies identified through Job Element Analysis. The value of validating the competency listing through a larger criterion group would add a greater degree of credibility to the data.

Determination of Participation

A summary of the study had already been presented to Specialized Home Care agencies statewide prior to submission of the study proposal. At that time, informal response was positive, with all agency representatives indicating an interest in participation. Upon acceptance of the dissertation proposal by committee members, a formal oral and written presentation of the proposed study was made to all Specialized Home Care Regional Directors and the Department of Mental Health's Statewide Coordinator. This presentation included the study purpose, methodology, design and the responsibilities any participating agency would be expected to assume. Proposed timelines for data collection were also discussed. Each Regional Director was asked to submit a written response to the author's request for participation.

Six of the seven possible regions opted for participation. Participating regions were I, II, IVA, IVB, V, and VI. Information on geographic territory covered by these regions is given in Appendix A.

Research and Human Subjects Clearances

The Massachusetts Department of Mental Health requires review and approval of any research to be con-

ducted within its funded programs. This is intended to protect client rights to confidentiality and to assure the appropriate and professional conduct of research activities. This research clearance is carried out by a Research Review Committee in each departmental region.

In order to circumvent the duplication involved in securing separate clearances for six individual regions, the author secured permission to apply the approval of one region's Research Review Committee to all other participating regions. Approval was granted by the Region I Research Review Committee in April of 1980. Regional Directors were responsible for securing any additional clearances required at the local level, such as consumer and citizen advisory boards.

Phase One, Data Collection and Analysis: Job Element Analysis

Assembling the job element panel. General criteria for the selection of panel members was finalized. In order to assure adequate representation from all six participating regions, it was decided that the Job Element Panel would be composed of nine members representing a mix of superior care providers and supervisors of care providers. General selection criteria for all panel members took into consideration fairness of attitude and absence of marked bias or prejudice regarding the Care Provider position.

Regions were asked to choose individuals who had demonstrated an interest in maintaining a high standard of proficiency.

Additional criteria suggested for the selection of care provider panel members were:

1. length of experience with the Specialized Home Care Project;

2. evaluation records throughout tenure;

3. history of contact with other Care Providers through training sessions, support groups or informal networks;

4. record of involvement with agency committees, activities or agencies working with the developmentally disabled; and,

5. availability and willingness to volunteer approximately 6 hours to the process.

Supervisory panel members were selected among Placement Coordinators and Regional Directors for the Specialized Home Care Project. Suggested criteria considered in their selection were:

1. length of experience with the Specialized Home Care Project;

2. number of care provider families they had supervised;

3. experience in assessing and licensing applicant care providers;

4. prior experience in working with the retarded; and,

5. willingness to participate in the study.

Names and information on prospective panel members were submitted by each region. Suggested members were approached to serve with a group considered "experts" on the position of Care Provider to identify the actual skills, abilities, attitudes and areas of knowledge that could be used to select superior care providers, rather than requirements in terms of job titles, educational courses or other traditional credentials. They were informed of the time commitment involved and given a brief explanation of the purpose of the study. Of those who expressed an interested willingness to participate, the final panel members were selected.

Every effort was made to select a final group which reflected a representative sampling of Care Providers taking into consideration care provider social status, race and educational background as well as age and degree of handicap of clients in placement.

Primoff recommends that the leader of the session be introduced by a highly regarded administrator who should emphasize the importance of the study and briefly explain the relevance of the study to the overall goals of the organization. The Statewide Coordinator for Specialized Home Care agreed to introduce the author as

the panel leader and also to participate in the panel activities.

Arrangements for the panel session were made. Letters were sent to all participants, briefly reviewing the purpose of the meeting and confirming the date and location.

Panel composition. The panel was composed of five care providers, four staff who supervised care providers and one state administrator. Brief data were collected on each member.

Care providers were represented by individuals who had experience with Specialized Home Care ranging from one and a half to five years. Only one of the five Care Provider panelists had foster care experience prior to Specialized Home Care and three of the five had previous experience with the retarded. Two had had some formal training in either foster care or working with the retarded besides that provided by Specialized Home Care. Clients receiving services from this group ranged in age from 2 to 45 years.

Staff supervisor's tenure with Specialized Home Care ranged from two to three and one half years. All had had experience with the developmentally disabled prior to Specialized Home Care employment. Only one of the four staff representatives had previous experience with foster

care and this experience was described as "limited". Three of the four had graduate degrees in social work or counseling and one had a bachelors degree in psychology with no graduate level training.

The administrator had ten years experience in human services, three of which had been in the capacity of Statewide Coordinator. Her training had been in social services. She had experience working with a variety of disabled populations including the mentally retarded.

The panel meeting.

Generating a list of elements and subelements. Following an introduction by the Statewide Coordinator, the panel leader began the meeting. In order to gain panel acceptance of the aims of the study, the panel leader discussed the nature of the Job Element Analysis procedure placing particular emphasis on the purpose of gathering elements and subelements. Situational examples were given for each.

The panel was then asked to begin generating elements for the position of Care Provider keeping in mind the prototype of superior performer. Each suggested element was written on newsprint. After the group had listed all the elements they apparently could think of, a brief break was taken. The panel reconvened to review each listed element and to list any subelements which might be

applicable to the elements. Once again, the panel leader provided hypothetical examples of subelements in relation to elements for a position other than Care Provider.

Once each element was reviewed and subelements had been generated the panel was asked to review the total list and to make any final suggestions for elements which had not been covered but which seemed appropriate. There was no need to check the appropriateness of designating an item as an element or subelement since the rating system described below was designed to refine these listings.

The final portion of the panel meeting included an explanation of the element and subelement rating system, which was to be carried out by panel members on an individual basis.

Rating of elements and subelements by panel members. Elements and subelements are rated in terms of four categories that pertain to job success, which are:

1. Barely Acceptable (B): What relative portion of even barely acceptable workers are good in this element?

2. Superior (S): How important is the element in picking out the superior worker?

3. Trouble (T): How much trouble is likely if the element is ignored when choosing among applicants?

4. Practical (P): Is the element practical? To what extent can we fill our job openings if we demand it?

Job Element Blanks, specifically designed for use

with the Job Element Analysis process, were used for the rating system (see Appendix B).

Panel members were given a full explanation, examples and review of the rating of each category. A few elements and subelements generated earlier in the session were rated at the panel meeting. When panel members indicated a complete understanding of the rating system, the session was concluded. Panel members were asked to return Job Element Blanks to the panel leader within one week and were encouraged to call the panel leader if any questions arose in the course of completing the ratings.

Analyzing data resulting from panel ratings. When all panel members had returned to the Job Element Blanks, the ratings were scored and calculated to produce several values. The purpose of the calculations is to find the elements which will distinguish superior workers. The formulas for calculation are based on numerical weights assigned to panel ratings. Primoff describes these weights as the result of previous multiple regression correlation studies in which ratings of applicants on elements were later correlated with success on a job.

The values determined through calculation include:

1. Item Index (IT): indicates the extent to which elements and subelements will select superior workers. If the Item Index reaches a level specified in the Job Element Procedure, the item may be usd as the basis for constructing tests, interview questions,

applicant self report lists or supervisory evaluation items.

The formula used is S X P + T, Superior X Practicality + Trouble Lidely. This means that the extent an element or subelement is useful in picking out superior workers is modified by the practicality of requiring it in addition to the trouble likely to be encountered if it is ignored.

2. Total Value as an Element (TV): indicates whether the item is broad and is an element, or is relatively narrow and is a subelement. The formula used for obtaining this value provides the maximum differentiation between Superior on the one hand and Barely Acceptable on the other. Items on the Job Elements Blanks with high Total Values are considered to be major elements.

   The formula for determining Total Value is IT + S - B - P. The Item Index is added to the group sum of superior; the group sum of the barely acceptable and practical columns are then subtracted from this total.

3. Training Value (TR): if an element or subelement rates high in superior and trouble likely, but low in practicality and barely acceptable, it is usually considered a valuable subject for a preservice or inservice training program. Such elements are also identified for later use in performance evaluation.

   The formula for determining the Training Value is S + T + (S X P)' - B. That is the group sums of Superior and Trouble Likely are first added; this is then added to the group sum for Superior times athe reversed group sum for Practical: Then the group sum for Barely Acceptable is subtracted.

4. Transmuted Values: Because different sized groups of raters affect the possible group sums, scores must be transmuted to provide a scale of values that will be constant across any size group of raters. The Barely Acceptable, Superior, Trouble Likely, Practical and Item Index values are transmuted

to a scale of 0 to 100. The Total Value and Training Value are transmuted to a scale of 50 to 150.

Once transmutation scores have been derived, various interpretations can be made. Those items which have a transmuted Total Value (TV) of over 100 are considered significant elements. These are areas of competence which cover a broad range of ability between barely acceptable and superior workers. These are useful in describing the general qualifications of a care provider, but are not specific enough to be used as a competency requirement, since they are difficult to measure precisely.

Those items which have transmuted Total Values (TV) of less than 100 and Item Indexes (IT) of more than 50 are considered significant subelements. For an entry level position, such as that of care provider, the Barely Acceptable value should also be considered. If the Barely Acceptable (B) transmuted value is less than 50, the item should be examined for possible elimination since many qualified workers tend to be low on such items. However if such items have a high transmuted value in Superior (S = 80 or more), it would relate to a high level of ability and would be considered worth maintaining.

Screenout subelements are those which would be considered necessary for minimum eligibility. These are usually items which have a Barely Acceptable (B)

transmuted value over 75 and a transmuted Trouble Likely (T) value of over 50. None of these were identified in the present study. If the item index is 50 or over and the item also has high (B) and (T) values, these items may also be considered for the purposes of screening out applicants above a certain required level. Several items meeting these specifications were identified and were considered required subelements.

The remaining subelements are considered the specific competency requirements for the position under study. Subelements with a transmuted Training Value (TV) over 75 are those which relate to superior performance but are not practical to expect. These are therefore competencies which are given high consideration for inclusion in a training curriculum.

The final listing of rated and transmuted elements and subelements is included in Appendix C. This was used as the basis for developing the questionnaires which were used in the final phase of the study.

Phase Two, Data Collection and Analysis: Care Provider and Supervisory Questionnaire

The questionnaire design and administration followed a modified version of survey design and administration procedures described by Dillman (1978).

Questionnaire design. Two similar questionnaires were designed for field based input from Care Providers and supervisors: a questionnaire for self assessment by Care Providers (Care Provider Questionnaire) and one for assessment of the Care Provider by a supervisor (Supervisory Questionnaire). Each included a listing of competency areas identified by the Job Element panel and a rating scale for each competency. The rating for both questionnaires was based on a response of 1 to 5. For all but a few items 1 was an indication of complete deficiency in the dsignated competency areas and 5 indicated superiority.

The Care Provider Questionnaire included a veracity scale developed from selected items of Crowne's and Marlow's Social Desirability Scale (Robinson & Shaver, 1973). This scale was designed to provide a basis for judging the truth of the Care Provider self ratings. Also contained on the Care Provider questionnaire was a procedure for Care Providers to identify knowledge and ability items which they considered most important to their success.

The Supervisory Questionnaire contained an additional general rating of the Care Provider as either superior or average as well as some questions on clientele, previous experience and training of the Care Provider.

An initial draft of the Care Provider Questionaire was field tested with three Care Providers from Region I, who were chosen based on their varying backgrounds and educational levels. These Care Providers were asked to review the qustionnaire in the presence of the author. They read it out loud and at any point where there was hesitation a discussion ensued regarding the ambiguity of the item. In a number of cases the Care Providers paraphrased what they thought the item meant and these words were then used for the final draft. Staff also were given the draft Care Provider Questionnaire for review and comment. A cover letter introducing the study and soliciting response was prepared for inclusion with the Care Provider Questionnaire (see Appendix D).

The Supervisory Questionnaire was developed by adapting the final version of the Care Provider Questionnaire. Staff were also asked to review this, but offered no comments which necessitated changes. A cover sheet explaining the study was also developed. The Supervisory Questionnaire is in Appendix E.

Administration of questionnaires.

Coding. For the purposes of confidentiality, all questionnaires were pre-coded. Each private agency was given a set of Care Provider Questionnaires with identifying numbers. They were asked to develop a coding

sheet which matched a Care Provider name with one of the identifying numbers. This was to be used when the author sent out supervisory questionnaires with the same identifying numbers of returned Care Provider questionnaires. Care Provider Questionnaires could therefore be matched with Supervisory Questionnaires. Unmatched questionnaires could not be used in the data analysis.

Distribution. Questionnaires were distributed to 165 practicing care providers from the six participating regions. A variety of techniques were used for distribution. Based on feedback from agencies, it was suggested that response might be better through personal delivery rather than the mail. In this way, the study could be explained again and any questions regarding the content of the questionnaire could be answered immediately. Some regions used group meetings for questionnaire distribution, several of which the author attended. Some regions also hand delivered the questionnaire through regularly scheduled home visits. Other regions mailed the questionnaires and followed up with phone calls. The remainder of Care Providers not receiving the questionnaire through personal contact received the questionnaire and cover letter through the mail.

As stated earlier, matched Supervisory Questionnaires were distributed for all returned Care

Provider Questionnaires. Supervisors were asked to complete and return their ratings of Care Providers directly to the author.

Statistical analysis. The major objective of statistical analysis was to compare the significance of difference in mean ratings of the superior group and the average group of Care Providers on competency areas. Individual items were organized around nine cluster areas which are described in Chapter five. Cumulative ratings for each cluster were compared. Care Provider self ratings and supervisory ratings were analyzed separately. Independent mean scores and significance of difference were determined by using a t-test for independent means.

Cross tabulation was performed on the total veracity score to examine variance between groups.

Group frequency distributions were attained for all other data.

Summary

Methodology for the study has been described. A rationale for the use of Job Element Analysis has been provided. This was followed by a description of the procedures and data analysis of each of the two major phases of the study: Job Element Analysis and questionnaire design, administration and analysis. As noted previously,

the results of Phase One are included in Appendix C. The results of the questionnaire data analysis will be presented in Chapter Five.

C H A P T E R V

RESULTS OF QUESTIONNAIRE

Introduction

This chapter presents the results of the Care Provider and Supervisory questionnaire administration and subsequent data analysis. The chapter begins with a report on the response rate from each region. This is followed by a presentation of the data obtained from the questionnaires. Demographic data, focusing on clientele and experience of the Care Providers, is summarized. The results of the veracity measure are presented next. This is followed by a presentation of competency areas which Care Providers had indicated as important. The final section of the chapter provides a presentation of differences in mean ratings between the superior and average groups. Data has been analyzed based on both the Care Providers' own ratings and those of their supervisors.

Response

Of the 165 Care Providers receiving questionnaires, 117 (70.9%) responded. Three of the returned Care Provider questionnaires were completed incorrectly and were therefore unusable in the data analysis. Table 1

provides breakdowns on return by each participating region.

One-hundred fourteen Supervisory questionnaires were distributed and 112 (98.2%) were returned. The final sample of Care Provider and Supervisory matched question-

TABLE 1

RESPONSE RATE

	REGION						
	I	II	IVA	IVB	V	VI	TOTAL
Care Provider Questionnaires							
Distributed	53	32	13	18	30	19	165
Returned	44	21	8	11	20	13	117
Response Rate (%)	83	65	61	61	66	68	70.9%
Unusable[a]	1	-	1	1	-	-	3
Supervisory Questionnaires							
Distributed	43	21	7	10	20	13	114
Returned	43	21	7	9	19	13	112
Response Rate (%)	100	100	100	90	95	100	98.2%
Matched Questionnaires							
Number	43	21	7	9	19	13	112
% of total sample	81	65	54	50	63	68	67.8%

[a]Questionnaires returned, but improperly completed.

naires was 112 representing 67.8% of the Care Providers from all regions. Of these matched responses, 47 Care Providers were rated as average and 65 were rated as superior.

Results of Data Analysis

Care Provider and Supervisory responses were analyzed by computer using the Statistical Package for the Social Sciences (SPSS). Results of data analysis are presented under four major categories: demographic data; veracity; critical items identified by Care Providers; and, differences in item ratings between superior and average Care Providers.

Demographic data. Frequency distributions for the superior, average and total groups were obtained for four areas of background information on Care Providers.

Length of time with Specialized Home Care. Care Providers' involvement with Specialized Home Care ranged from less than one to more than five years. The majority (51.8%) of the respondents had between two and four years experience as Care Providers. There was no significant difference between the superior and average groups in terms of length of time with Specialized Home Care although a higher percentage of the average group had four or more years experience and a higher percentage of

the superior group had less than two years experience. (See Table 2.)

TABLE 2

LENGTH OF TIME WORKING WITH SPECIALIZED HOME CARE

Number of Years	Average group		Superior group		Total group	
1 yr. or less	2.1%	(1)	4.6%	(3)	3.6%	(4)
13 mo.-2 yrs.	6.4%	(3)	20%	(13)	14.3%	(16)
25 mo.-3 yrs.	19.1%	(9)	23.1%	(15)	21.4%	(24)
37 mo.-4 yrs.	34%	(16)	27.7%	(18)	30.4%	(34)
49 mo.-5yrs.	17%	(8)	12.3%	(8)	14.3%	(16)
5 yrs.+	12.8%	(6)	4.6%	(3)	8%	(9)
No response	8.5%	(4)	7.7%	(5)	8%	(9)

Clientele. Data was obtained on the number of clients per home and the ages of clients served by the respondents. Slightly less than half (48.2%) of the respondents provided placement for only one client and slightly less than a quarter (22.3%) provided placement for two clients. The remainder of the respondents was represented by Care Providers who were providing placement for 3 or more clients, those who routinely provided respite care, or those who did not presently have place-

ments, but who had experience.

Respondents provided placements for both children and adults. Fifty-eight percent of the clients were 20 years or younger, 33% were between 20 and 40 years of age and only 8.5% were over 50 years old. Superior Care Providers provided placement for a younger population than the average group. Fifty-two percent of the clients in placement with the average group were over 20 years old, as opposed to 33% with the superior group.

Previous experience in foster care and mental retardation. Information was obtained on previous foster care experience and previous experience with the mentally retarded. A little less than 50% of the respondents in both the superior and average groups had prior experience with foster care. Foster care experience covered a broad spectrum with no major differences between groups (see Table 5).

Over 50% of the total group had experience with the mentally retarded outside of Specialized Home Care. Sixty-six percent of the superior Care Providers and only 44% of the average Care Providers composed the experienced group (see Table 6).

Training outside of Specialized Home Care. Only nine (17.1%) of the average Care Providers had training other than that provided through Specialized Home Care. Thirty-one (41.6%) of the superior Care Providers had

TABLE 3

NUMBER OF CLIENTS
PER HOME

Number of Clients	Average group		Superior group		Total group	
1	46.8%	(22)	49.2%	(32)	48.2%	(54)
2	23.4%	(11)	21.5%	(14)	22.3%	(25)
3	8.5%	(7)	10.8%	(7)	9.8%	(11)
More than 3	4.3%	(2)	--	--	1.8%	(2)
Variable (respite care)	6.4%	(3)	4.6%	(3)	5.4%	(6)
None	4.3%	(2)	1.5%	(1)	2.7%	(3)
No response	6.4%	(3)	12.8%	(8)	9.8%	(11)

TABLE 4

AGES OF CLIENTS
IN PLACEMENT

Years of Age	Average[a] group		Superior[b] group		Total[c] group	
0 - 5 yrs.	3.6%	(2)	9.3%	(7)	6.9%	(9)
6 - 10 yrs.	9.1%	(5)	17.3%	(13)	13.8%	(18)
11 - 20 yrs.	34.5%	(19)	40.0%	(30)	37.6%	(49)
21 - 40 yrs.	43.6%	(24)	25.3%	(19)	33.1%	(43)
over 40 yrs.	9.1%	(5)	8.0%	(6)	8.5%	(11)

[a]representing clients in 74.4% of the homes

[b]representing clients in 75.3% of the homes

[c]representing clients in 75% of the homes

TABLE 5

FOSTER CARE EXPERIENCE PRIOR TO WORKING WITH SPECIALIZED HOME CARE

Type Experience	Average group	Superior group	Total group
No experience	55.3% (26)	52.3% (34)	53.5% (60)
DSS Foster Care[a]	6.4% (3)	10.8% (7)	8.9% (10)
DMH Family Care[b]	6.4% (3)	9.2% (6)	8.0% (9)
Was foster child	---	3.1% (2)	1.8% (2)
Short term f.c.	4.3% (2)	---	1.8% (2)
Adolescent f.c.	6.4% (3)	3.1% (2)	4.5% (5)
Foster care through another private agency	6.4% (3)	6.2% (4)	6.3% (7)
Respite care	---	3.1% (2)	1.8% (2)
Other	8.5% (4)	.9% (1)	4.46% (5)
No response	2.7% (3)	6.3% (7)	8.9% (10)

[a]DSS = Massachuetts Department of Social Services
[b]Former family care program operated by the Massachusetts Department of Mental Health

TABLE 6

EXPERIENCE WITH MENTAL RETARDATION PRIOR TO WORKING WITH SPECIALIZED HOME CARE

Type Experience	Average group	Superior group	Total group
No experience	46.8% (22)	29.2% (19)	36.6% (41)
Volunteer	6.4% (3)	3.1% (2)	4.5% (5)
Friends of Care Providers	2.1% (1)	1.5% (1)	1.8% (2)
Own retarded child	4.3% (2)	3.1% (2)	3.6% (4)
Retarded family member	2.1% (1)	7.7% (5)	9.8% (11)
Friends had retarded child	---	4.6% (3)	3.6% (4)
House manager	---	9.2% (6)	5.4% (6)
Nursing home employee	---	3.1% (2)	1.8% (2)
Employee at institution	4.3% (2)	7.7% (5)	6.3% (7)
Student field work	---	1.5% (1)	.9% (1)
Respite care	---	3.1% (2)	1.8% (2)
Foster parent of mentally retarded through another agency	6.4% (3)	9.2% (6)	8.0% (9)
Teacher aid	2.1% (1)	1.5% (1)	1.8% (2)
Spec. Ed. Teacher	---	1.5% (1)	.9% (1)
Other	17.0% (8)	9.2% (6)	12.5% (14)
No response	8.5% (4)	4.6% (3)	6.3% (7)

received other training from a variety of sources (see Table 7).

TABLE 7

TRAINING IN FOSTER CARE OR MENTAL RETARDATION OTHER THAN SPECIALIZED HOME CARE TRAINING

Type Training	Average group	Superior group	Total group
No training	74.5% (35)	52.3% (34)	61.6% (69)
Thru other employment	6.4% (3)	9.2% (6)	8.0% (9)
General workshops	6.4% (3)	4.6% (3)	5.4% (6)
DSS Title XX courses	2.1% (1)	7.7% (5)	5.4% (6)
College courses	2.1% (1)	6.2% (4)	4.5% (5)
Cert. or Masters Spec. Ed.	---	4.6% (3)	2.7% (3)
Nursing school	---	3.1% (2)	1.8% (2)
Respite care training	---	3.1% (2)	1.8% (2)
Other	2.1% (1)	3.1% (2)	2.7% (3)
No response	6.4% (3)	6.2% (4)	6.3% (7)

Veracity. The five True/False items from Crown and Marlowe's Social Desirability Scale were computed to yield scores between 0 and 5, 0 indicating a high need for social desirability, and 5 indicating a low need. Veracity of Care Provider responses was then estimated by attributing low veracity estimates to those Care Providers who had scores between 0 and 1, medium veracity to those between 2 and 3, and high veracity to those between 4 and 5. A 2 X 3 chi square analysis was then performed to investigate differences in veracity between the superior and average groups (see Table 8).

TABLE 8

VERACITY[a,b]

Level of Veracity	Average group	Superior group	Total group
Low (0-1)	31.9% (15)	30.8% (20)	31.3% (30)
Medium (2-3)	51.1% (24)	38.5% (25)	43.8% (49)
High (4-5)	17.0% (8)	30.8% (20)	25.0% (28)

[a]as measured by responses to items from the Social Desirability Scale

b $\chi^2 = 3.063$, df = 2, p = .2161

The chi square analysis did not yield a significant level of difference between groups. However, as can be seen in Table 8, 30.8% of the superior, as opposed to only 17% of the average group, scored in the high veracity range. This may indicate a trend on the part of the average Care Providers in this sample to inflate their scores somewhat more than those in the superior group.

Items identified as important by care providers. Care Providers were asked to choose 5 items which they felt were important to their work or success after completing the first two sections of the questionnaire and again after completing the third section. The ten items most frequently identified by the total group as most important are listed below in order of priority.

1. Having a circle of friends/relatives who support and assist in my role as a Care Provider
2. Knowledge of normalization
3. Ability to identify client skill needs
4. Knowledge of total communication
5. Ability to gain information on the client through observation
6. Knowledge of emergency procedures
7. Having a good relationship with the client's day program
8. Using consistent methods and approaches with the client
9. Ability to teach the client self-esteem/ self-awareness

10. Understanding the client's feelings

The ten items which were least frequently identified, or not identified at all are as follows:

1. Educating extended family members about Specialized Home Care
2. Educating extended family members about mental retardation
3. Listening skills
4. Knowledge of the history of retardation (how it was managed in the past)
5. Understanding human sexuality
6. Educating the general community about Specialized Home Care
7. Presenting a positive image of Specialized Home Care
8. Teaching the client about sexuality
9. Sexual rights of clients
10. Correct and safe bathing and dressing techniques for physically handicapped clients

Differences in competency ratings between superior and average Care Providers. The major purpose of the study was to determine those items (competency areas) which distinguished superior from average Care Providers. The self ratings and supervisory ratings of Care Providers were used for this analysis.

For the purposes of data analysis, competency areas were grouped within nine realms. Following is a listing of realms under which the competencies were

organized:

1. General Personal Characteristics
2. Mental Retardation
3. Teaching and Client Development
4. Advocacy and Legal Rights
5. Health and Safety
6. Program Maintenance
7. Behavior Management
8. Normalization
9. Counselling

Raw scores for items in each realm were added in order to compute a total score for each realm. Where necessary, scores were recoded to correspond with the standard pattern of 1 indicating low proficiency in a competency area and 5 indicating high proficiency. Two sets of total scores in each realm, one based on self ratings and one on the supervisory ratings, were then used to perform t-tests of independent means between average and superior group realms.

General personal characteristics realm. This realm, which included the largest number of items, relates to the broader personal qualifications effecting the work performance of the Care Providers. The areas included in this realm were:

*2. Honesty

3.,8., 34. Ability to work with a variety of people (e.g. social workers, medical personnel, school administrators)

4. Sincerity

6. Belief in Care Provider learning

9. Commonsense

17. Patience

19. Eagerness to learn (willingness to learn new skills to meet client needs)

21. Compassion

24. Adaptability

26. Ability to follow directions

29. Self assurance/confidence in self

32. Respect for others

39. Objectivity

48. General communication skills

50. Recognition of own limitations

52. Self-control

57. Ability to get to appointments

59. Flexibility

61. Awareness and admission of own weaknesses

68. Determination

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*Numbers of competency areas correspond with numbers on the list of competencies resulting from Job Element Panel ratings (Appendix C). This numbering procedure is followed throughout the remainder of the dissertation.

70. Persistance, endurance

79. Acceptance of own mistakes

79. Acceptance of client mistakes

88. Ability to present a positive image of Specialized Home Care

88. Ability to present a positive image of working with the retarded

89. Ability to express own feelings

100. Having a natural support system (friends/ relatives who support and assist)

The highest possible cumulative score in this realm was 115.

As can be seen in Table 9, Care Provider self ratings in the General Personal Characteristics realm were not significantly different. The mean of the average group self ratings was 91.6 and the mean of the superior group was 93.9. Application of the t-test determined a t-value of 1.36, significant at the .177 level.

TABLE 9

DIFFERENCES BETWEEN SUPERIOR AND AVERAGE GROUP MEAN RATINGS IN GENERAL PERSONAL CHARACTERISTICS REALM

	Average			Superior		t-	
	N	Mean	SD	N	Mean	SD	val.	Sig.
Self ratings								
	36	91.6	8.2	59	93.9	7.2	1.36	.177
Supervisory ratings								
	44	78.3	12.7	65	101.1	8.5	11.15	<.0001

Supervisors rated the average group significantly lower than the superior Care Providers. According to supervisory ratings, the General Personal Characteristics realm had a mean score of 78.3 for average Care Providers and 101.1 for superior Care Providers. The t-value was determined to be 11.15, significant at greater than the .0001 level.

Differences between mean ratings on individual items with the General Personal Characteristics realm were also determined by a t-test. The results of these individual item t-tests are included in Appendix F. Mean ratings of the average and superior groups by supervisors showed a significant difference ($p \leq .05$) in all areas in the realm. According to Care Provider self ratings, the four individual competency areas in which there was a significant difference ($p \leq .02$) were:

19. Eagerness to learn

88. Ability to present a positive image of Specialized Home Care

88. Ability to present a positive image of working with the retarded

89. Ability to express own feelings

Whenever willingness or eagerness to learn are identified by the Job Element Panel, as in this study, this may be more important than other competency areas when selecting the employee. Other competency areas, identified through the study, should all be assessed in

light of their potential for acquisition through on the job experience or training.

Mental retardation realm. Competency areas included in the mental retardation realm were those specific to the field of mental retardation. They are:

65. General knowledge about mental retardation

80. Ability to educate the community about Specialized Home Care

80. Ability to educate the community about working with the retarded

84. Ability to educate extended family members about Specialized Home Care

84. Ability to educate extended family members about working with the retarded

95. Knowledge of the history of mental retardation

106. Knowledge of terminology in the field of mental retardation

The total cummulative score possible for this realm was 35.

As presented in Table 10, both the Care Provider self ratings and the supervisory ratings distinguished the superior from the average group in this realm. Ratings by supervisors produced mean scores of 20.62 and 28.03 for average and superior groups respectively. The t-value was determined to be 7.9, significant at greater than the .0001 level.

For self ratings in the mental retardation realm, the average group mean was 24.3 and the superior group mean was 28.03. The t-value was 2.9 and the significance

level .005. Since both supervisors and Care Providers rated the groups as significantly different in this realm, it is interesting to consider the individual competency areas which contributed to the differences between groups.

TABLE 10

DIFFERENCES BETWEEN SUPERIOR AND AVERAGE GROUP MEAN RATINGS IN THE MENTAL RETARDATION REALM

	Average			Superior			
N	Mean	SD	N	Mean	SD	t-val.	Sig.
Self ratings							
42	24.3	5.6	60	27.1	3.9	2.9	.005
Supervisory ratings							
45	20.62	5.6	65	28.03	4.2	7.95	<.0001

All items, as rated by the supervisors and Care Providers, achieved a significance level of at least the .05 level. Self ratings of Ability to educate extended family about Specialized Home Care and ability to educate the general community about mental retardation achieved the greatest significance levels ($p \leq .007$ and $p \leq .014$ respectively). Knowledge of the history of mental retardation, knowledge of terminology, and ability to educate extended family about mental retardation, based on self ratings, had the least significance of difference.

Teaching and client development realm. The teaching and client skill development realm included competency areas which related closely to client habilitation and training functions. These were:

10. Overall teaching skills

28. Ability to teach client decision making

30.,97. Ability to teach activities of daily living

37. Observation skills

40. Ability to teach client respect for others

47. Ability to teach client self-esteem self-awareness

53. Ability to teach self-preservation

56. Ability to identify client skill needs

62.,67. Ability to teach client community living skills

73. Task analysis

81. Ability to teach client about sexuality

87. Understanding of human sexuality

92. Ability to teach client flexibility

93. Total communication

101. Organizing skills (organizing time and planning activities)

104. Knowledge of child development

The highest possible cumulative rating in this realm was 80.

In this realm, a significant difference between superior and average groups was only indicated by the

supervisory ratings. The mean score based on supervisory ratings was 51.8 for the average group and 66.4 for the superior group. The average Care Providers rated themselves at a mean of 58 as opposed to the mean of 60.4 based on superior self ratings.

TABLE 11

DIFFERENCES BETWEEN SUPERIOR AND AVERAGE GROUP MEAN RATINGS IN THE TEACHING AND CLIENT DEVELOPMENT REALM

	Average			Superior		t-	
N	Mean	SD	N	Mean	SD	val.	Sig.
Self ratings							
35	58.0	6.8	49	60.4	7.5	1.5	.137
Supervisory ratings							
43	51.8	8.2	55	66.4	6.8	8.3	<.0001

As can be seen in Appendix F, the differences between mean ratings was significant for all the competency areas as rated by supervisors. No items were rated significantly different based on superior and average group self ratings, although overall teaching skills, rated as a major element by the Job Element Panel, and ability to identify client skill needs, which was rated as a subelement, reached significance levels of .079 and .07 respectively.

Advocacy and legal rights realm. Six competency areas were grouped under the realm of advocacy and legal rights, as follows:

25. Knowledge of client's emotional rights

43.,55. Overall knowledge of client's legal rights

49. Knowledge of client's sexual rights

60. Knowledge of Care Provider rights

86. Ability to compromise

98. Advocacy skills

The highest possible score to be given in this realm was 30.

Supervisory ratings produced mean scores of 18.4 and 23.4 for the average and superior groups respectively (see Table 12). The t-test applied to the means resulted in a value of 7.15 indicating a significance level of greater than .0001.

TABLE 12

DIFFERENCES BETWEEN SUPERIOR AND AVERAGE GROUP MEAN RATINGS IN ADVOCACY AND LEGAL RIGHTS REALM

	Average			Superior		t-	
N	Mean	SD	N	Mean	SD	val.	Sig.
Self ratings							
43	17.5	2.7	61	18.2	2.7	1.23	.221
Supervisory ratings							
47	18.4	3.8	63	23.4	3.1	7.15	<.0001

The mean self rating for average Care Providers was 17.5 and for superior Care Providers 18.2. The t-value was 1.23, significant at only the .221 level. Only one individual competency area, as rated by Care Providers, approached a significance level of consideration ($p \leq .081$). This area was ability to compromise. Once again, supervisors differentiated superior from average Care Providers for all competency areas in this realm.

Health and safety realm. Table 13 provides data on the cummulative supervisory and self ratings in competency areas relating to client physical health and safety. The areas included in this realm were:

13. Ability to recognize symptoms of health problems
50. Knowledge of good nutrition
51. Knowledge of basic fire prevention/fire safety
71. Homemaking skills
82. Knowledge of first aid
82. Knowledge of Cardio Pulmonary Rescusitation (CPR)
82. Knowledge of the Heimlich maneuver
85. Ability to administer oral medications
90. Knowledge of emergency procedures
91. Bathing and dressing techniques for physically handicapped clients
96. Knowledge of required authorizations

102. Knowledge of how to handle seizures

The highest attainable score in the health and safety realm was 60.

Supervisors' mean ratings were 40 and 46.4 for the superior and average groups respectively. The application of a t-test to the supervisory means yielded a t-value of 4.02, significant at greater than the .0001 level. Self ratings produced mean scores of 42.7 for the average group and 43.2 for the superior group. In contrast to the significance of difference between groups as indicated by supervisory ratings, the t-test of self rating means yielded a t-score of .28, significant at only the .778 level. It is surprising to find such a dramatic difference in significance levels, particularly since the assessment of proficiency in many items of this realm would seem to be much more clearcut (e.g. knowledge, skill and ability competencies) than many of the items composing other realms.

As can be seen in the individual item analysis in Appendix F, the only competency area reaching a significance level from both supervisory and self ratings was ability to recognize symptoms of health problems. Two items in the Health and Safety Realm did not reach significance under the t-test of either self or supervisory mean ratings. These were: Ability to administer oral medications and Knowledge of how to handle seizures.

TABLE 13

DIFFERENCES BETWEEN SUPERIOR AND AVERAGE GROUP MEAN RATINGS IN HEALTH AND SAFETY REALM

	Average			Superior			
	N	Mean	SD	N	Mean	SD	t-val.	Sig.
Self ratings								
	38	42.7	7.7	62	43.2	6	.28	.778
Supervisory ratings								
	30	40	7.2	46	46.4	6.1	4.02	<.0001

Program maintenance realm. Only five competency areas were grouped under the Program Maintenance realm. These were items which related to working within the human service system, most closely approximating the competency areas relating to administration and service coordination functions. The competency areas included in this realm were:

18. Cooperation with agency policies

63. Ability to establish a good realtionship with the client's day program

76. Ability to read and interpret written information on the client

77. Understanding the Specialized Home Care service system (who does what and who is responsible for what)

105. Ability to gain necessary client information

The highest cummulative score possible for items in this

realm was 25.

It is interesting to see that this realm differentiated the superior and average groups based on both supervisory and self ratings. The mean score derived from self ratings was 19.9 for the average group and 20.8 for the superior group. The t-test applied to these means yielded a t-value of 2.05, significant at the .044 level.

TABLE 14

DIFFERENCES BETWEEN SUPERIOR AND AVERAGE GROUP MEAN RATINGS IN PROGRAM MAINTENANCE REALM

	Average			Superior		t-	
	N	Mean	SD	N	Mean	SD	val.	Sig.
Self ratings								
	40	19.9	2.5	62	20.8	2	2.05	.044
Supervisory ratings								
	44	16.8	3.8	62	21.3	2.1	7.91	<.0001

Differences in supervisory mean ratings were much greater. The supervisory mean for the average group was 16.8 and for the superior group 21.3. The t-value attained was 7.91, significant at greater than the .0001 level.

Based on Care Provider self-ratings, Cooperation with Agency policies was the only individual competency

area to achieve a significance level greater than .01 (see Appendix F). This was a subelement rated high by the Job Element Panel (18th out of 105). Understanding the Specialized Home Care service system approached a high significance level of .072. All supervisory ratings of competency areas in this realm showed a significant difference in means between groups at greater than the .0001 level.

Behavior management realm. Table 15 provides results of cumulative ratings for competency areas relating to behavior management. These were items which were considered important to successfully working with client behavior problems. Included in this realm were:

14. Ability to respond to client consistently (using consistent methods and approaches with client)

20. Home consistency (getting all members of household to work consistently with client)

38. Skills in working with inappropriate behavior

67. Ability to set realistic limits on client (e.g. food intake, television, etc.)

The highest score possible for this realm was 20.

Based on Care Provider and Supervisory ratings, the Behavior Management realm is one which distinguishes the superior from the average performer. Mean scores derived from Care Provider self ratings were 15.3 for the average group and 16.1 for the superior group. The t-value for these two means is 2.08 significant at the .04

level.

TABLE 15

DIFFERENCES BETWEEN SUPERIOR AND AVERAGE GROUP MEAN RATINGS IN BEHAVIOR MANAGEMENT REALM

	Average			Superior		t-	
	N	Mean	SD	N	Mean	SD	val.	Sig.
Self ratings								
	41	15.3	1.7	64	16.1	2.1	2.08	.04
Supervisory ratings								
	42	12.4	3.2	62	16.5	2.1	7.7	<.0001

Supervisory ratings produced mean ratings of the superior group at 16.5 and the average group at 12.4. The t-value of these two scores was 7.7 at a greater than .0001 level of significance.

The supervisory mean ratings of Care Providers on individual competency areas within this realm were all significant at greater than the .0001 level. When the t-test was applied to superior and average Care Provider mean self ratings, all items but one produced a significance level greater than .01 (see Appendix).

Normalization realm. Competency areas grouped under the normalization realm were those which were closely aligned with concepts related to the principle of

normalization and the developmental model. They were:

16. Belief in continuous client learning.

41. Knowledge of danger of labelling

42. Belief in the client's right to take risks

46. Knowledge of the importance of age-appropriate activities

72. Knowledge of normalization principle

99. Not overprotective

The highest score possible for this realm was 30.

Supervisory mean ratings of average Care Providers in the normalization realm was 19.3 as opposed to a 25.4 mean rating of the superior group. Application of the t-test to these means yielded a 7.62 t-value which is significant at greater than the .0001 level.

Average Care Providers rated themselves slightly higher than did their supervisors, with a mean score of 20.9. The superior group mean self rating at 21.9 was lower than their supervisors' rating. The t-value determined through a t-test of self rating means was 1.36, significant at the .176 level.

All individual item t-tests between average and superior means on supervisory ratings were significant at a level greater than .0001. None of the t-tests between means based on self ratings were significant beyond the .01 level.

TABLE 16

DIFFERENCES BETWEEN SUPERIOR AND AVERAGE GROUP MEAN RATINGS IN NORMALIZATION REALM

	Average			Superior			
	N	Mean	SD	N	Mean	SD	t-val.	Sig.
Self ratings								
	41	20.9	3.7	61	21.9	3.5	1.36	.176
Supervisory ratings								
	46	19.3	5.2	64	25.4	3.1	7.62	<.0001

Counselling realm. The counselling realm contained seven competency areas. These were:

1. Understanding the client's feelings
4. Sensitivity to unspoken problems of client
15. Ability to work with the client's biological family
33. Listening skills
54. Understanding the feelings of the client's biological family
75. Support counselling skills
94. Ability to interpret non-verbal communication of the client

The highest possible cummulative rating for this realm was 35.

Average and superior Care Providers rated themselves very similarly in the counselling realm. The

average group had a mean score of 26.9 and the superior group 27.3. The t-value was .55, significant at the .585 level.

TABLE 17

DIFFERENCES BETWEEN SUPERIOR AND AVERAGE GROUP MEAN RATINGS IN COUNSELLING REALM

	Average			Superior		t-	
	N	Mean	SD	N	Mean	SD	val.	Sig.
Self ratings								
	28	26.9	2.7	43	27.3	3.8	.55	.585
Supervisory ratings								
	33	22.2	5	56	28.8	3.6	7.09	<.0001

Supervisory ratings of the average group produced a mean rating of 22.2 and a mean rating of the superior group of 28.8. The t-test between these means yield a t-value of 7.09, significant at greater than the .0001 level.

T-tests between supervisors' mean ratings on individual competency areas within this realm were all significant at the .003 level or more. T-tests based on mean self ratings showed only one competency area to significantly differentiate the superior from the average group: support counselling skills. Another which was close to

significance ($p \leq .088$) was ability to interpret non-verbal communications of client.

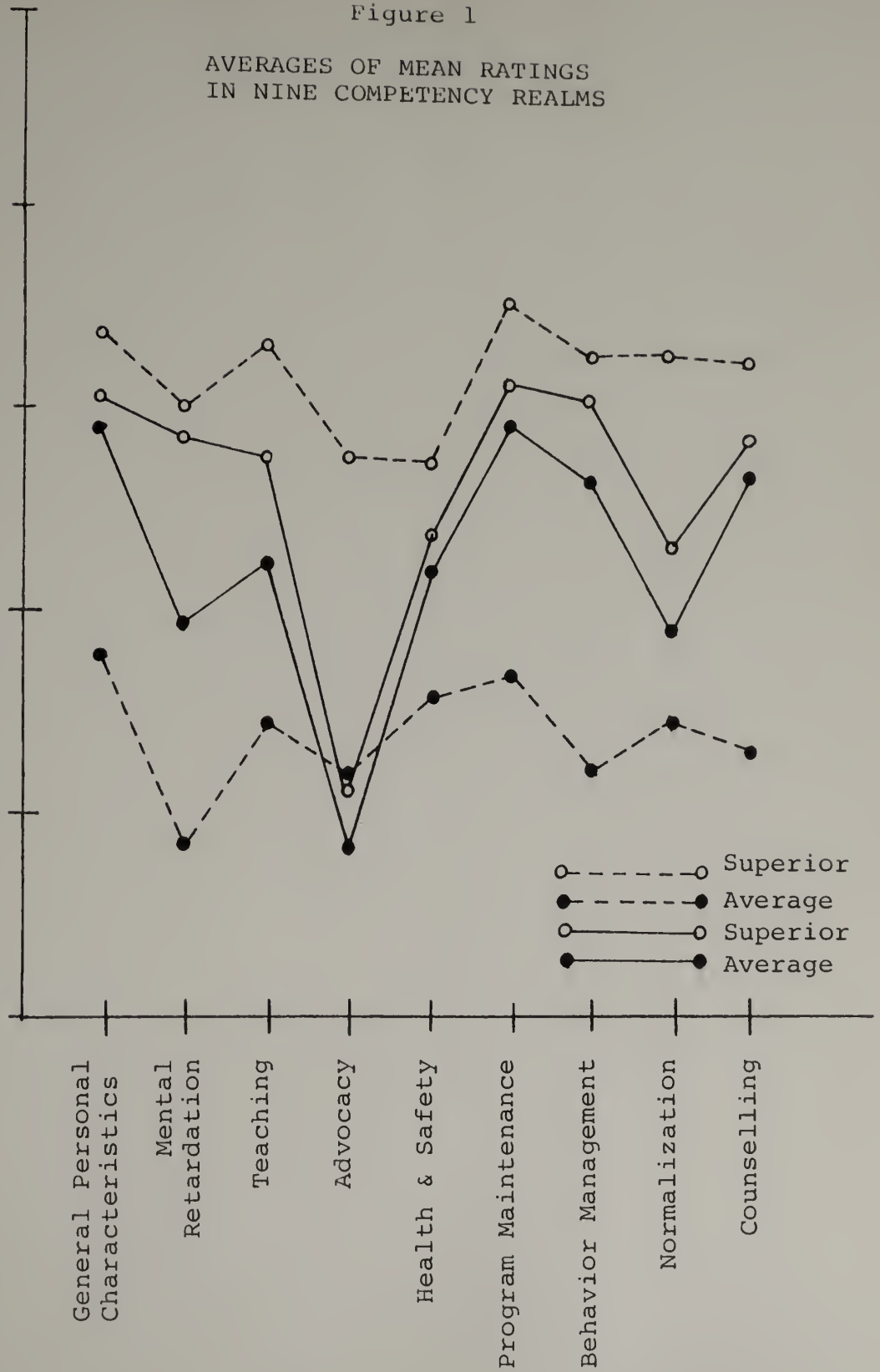
Overall ratings in all realms. Besides studying the comparisons of mean ratings within each realm, it is also useful to consider the differences in mean ratings between realms. In this way, a picture of the overall competence levels of Care Providers in the sample can be attained. Figure 1 provides a composit picture of the average of mean ratings for each realm. Averages were computed by dividing the cumulative mean ratings for the realm by the number of items in the realm.

The supervisors consistently ranked average Care Providers in the 3.0 to 3.5 range which indicated some level of proficiency in the area, with room for improvement. According to self ratings, average Care Providers fell between 3.5 and 4 in all realms but the Advocacy and Legal Rights realm. In this realm they, along with superior Care Providers, rated themselves between 2.9 and 3, indicating only limited competence.

Supervisory ratings of superior Care Providers, ranging from 3.8 to 4.3, clearly differed from their ratings of the average group. This range correlates with a rating of general proficiency without need for additional assistance or training. Superior Care Providers rated themselves somewhat lower than their supervisors,

Figure 1

AVERAGES OF MEAN RATINGS
IN NINE COMPETENCY REALMS



with the greatest contrast being in the realms of Advocacy and Legal Rights, Teaching and Client Development, Normalization, and Counselling.

The overall differences between the superior and average self ratings might have been greater if the veracity measure of average care Providers had been equal to that of the superior group. Assuming the validity of the veracity measure, average Care Provider self ratings were inflated somewhat more than their superior counterparts.

Summary

The results of quesionnaire data analysis have been presented in this chapter. Length of time working with Specialized Home Care, number of clients per home and ages of clients served did not appear to distinguish the superior from the average group. Foster care experience other than Specialized Home Care was very similar for both groups. Experience with mental retardation prior to Specialized Home Care did differ between groups, with 66% of the superior group having prior experience and only 44% of the average group. Along similar lines, the superior group tended to have more training besides that provided by Specialized Home Care (41.5%) than the average group (19.1%).

The results of the veracity scale, though not statistically significant, showed a possible tendency for the

superior Care Provider responses to have greater legitimacy than those of the average group.

The differences between mean ratings on nine major realms of competence were identified. The realms relating to mental retardation, program maintenance and behavior management competencies consistently reflected differences between groups based on both self and supervisory ratings. T-test of the supervisory mean ratings of the superior and average Care Providers in the other six realms all resulted in high significance levels ($p \leq .0001$). T-values derived from self rating means in these six realms did not achieve significant levels. Differences between individual item ratings within each realm were also discussed.

Chapter Six, the final chapter of the dissertation, will provide further discussion of the results. Recommendations and conclusions will also be included in this chapter.

C H A P T E R V I

DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

Introduction

This chapter considers the results of the study primarily from a program development perspective. The goal implicit in the study has been to assure greater quality of care for individuals with mental retardation residing in family care settings. It was proposed that this might best be accomplished through improved systems of family care provider selection, evaluation and training.

The major objective of the study was to identify the criteria critical to success as a Care Provider for the Specialized Home Care Project and to use that criteria as the foundation for a competency based Care Provider development system. As such, the content of this chapter focuses on an interpretation of the results and methodology for the further design of a competency based program. The first part of the chapter provides a general discussion of the questionnaire results. This is followed by two sections: one which addresses the objectives of the study and one which recommends approaches to further development of a competency based program. A section on

recommendations for future research is followed by conclusions and summary statements.

General Discussion of Results

The basic theory upon which the Job Element Analysis methodology rests is that a wide variety of characteristics, including skills, abilities, personal characteristics and areas of knowledge, contribute to performance in a job. When those characteristics which are critical to outstanding performance are identified, they are extremely useful to the process of establishing various forms of worker evaluation and development, including credentialing or licensing plans and training curricula. Based on this theory and the assumed validity of the Job Element methodology, the results indicate a wide range of qualifications which influence performance as a Care Provider.

In the first phase of the study the Job Element Panel generated and rated a long list of skills, abilities, personal characteristics and areas of knowledge which were suggested as important for successful performance as a Care Provider. The rating system designed by Primoff results in several values which indicate the relative importance of the competencies generated by the panel for either training, selection or performance evaluation purposes.

The second phase of the study, carried out through the supervisory and Care Provider questionnaire administration, provided for field based input from practicing Care Providers and their supervisors. The results of the data generated through the questionnaire are intended to provide verification of the Job Element Panel's work based on an analysis of supervisory and self ratings of superior and average Care Providers. Any competencies for which a significant difference between superior and average performers is found, based on these ratings, are considered valid for further use in the design of a competency based system. Any competency for which both the self and supervisory ratings indicated no significant difference between groups is either discarded or given lowest priority in implementation of a competency based system.

In this study all but two competency areas achieved significant ratings. The two which did not are: ability to administer oral medications and knowledge of how to handle seizures. Both these competency areas also achieved low rankings by the Job Element Panel. Based on these results, these could probably be eliminated from a Care Provider credentialing or training system and only considered based on the needs of an individual client.

According to the results of the questionnaire data analysis, all other competencies identified by the Job

Element Panel and included in the questionnaire do contribute to some difference between the average and superior Care Provider.

Differences in ratings by supervisors and care providers. As presented in Chapter Five, the supervisory mean ratings indicated a much wider and more definitive difference between superior and average Care Providers on almost all the competency areas. The supervisors' ratings resulted in significance for 84 of 86 competency areas. In contrast, the self ratings by the superior and average groups were much more homogeneous. Self ratings resulted in only nine out of 86 competency areas achieving significance.

There are several interpretations which can be given these patterns. In regards to the supervisory ratings, the fact that supervisors had to first provide a general rating of the Care Provider as either superior or average may have influenced their subsequent ratings of the Care Provider within individual competency areas. In other words, the supervisor's ratings may have been influenced by a halo effect whereby when overall impressions about the Care Provider were highly positive, the supervisor might tend to rate the Care Provider in an overall high pattern and when negative or less positive, to rate the Care Provider in an overall low pattern.

The closeness of Care Provider self ratings may

have been due to both a higher level of aspiration among the individuals composing the superior group and thus a more stringent self assessment standard and by a tendency on the part of the average group to inflate their ratings more than the superior group due to a higher need for social desirability.

In a later section of this chapter the author will suggest some alternatives to the self and supervisory rating which might be used in future studies of this kind.

Objectives of the Study

The specific objectives of this study were to:

1. Identify competencies which are significant to superior performance as a Care Provider,

2. Identify competencies useful for consideration in the initial screening and evaluation of applicant Care Providers, and

3. Identify competencies highly suitable for inclusion in preservice and inservice training curricula. The discussion in this section addresses these three objectives.

Since all but two of the competency areas identified within the first phase of the study were found statistically significant in the second phase, all but these two items have been verified as significant to superior performance. Through continued utilization of the panel's

ratings, further interpretations can now be made regarding these competency areas.

As discussed in Chapter Four, Primoff's rating system produces several values for each competency area which are indicative of the practicality, trouble likely and relative importance of competency areas in distinguishing superior performance. These values can be further interpreted through formulas developed by Primoff to indicate competencies which are broad requirements for performance in the position under study (Major Elements), those which will most likely result in problems if they are not required (Required Subelements), those which should be considered when developing selection or credentialing plans (Subelements), and those which may not be practical to expect of applicants but which relate to performance and should therefore be considered for inservice training and development purposes (Training Subelements). Though Primoff has established parameters for interpreting the values, he makes allowances for flexibility in establishing cutoff points. For example, he suggests that when many competency areas achieve high training values, which frequently occurs when items like willingness to learn or eagerness to learn are listed by the Job Element Panel, the meaning of the training value is subject to interpretation by the job analyst.

An interpretation of the rating system provides

the following framework for a competency based system for the Specialized Home Care Provider.

Major elements. Broad requirements for outstanding performance as a Care Provider are:

1. Having an understanding of the client's feelings
2. Honesty
3. Ability to work with a variety of people
4. Sensitivity to unspoken problems of the client
5. Understanding and accepting role with client
6. Willingness to learn new skills to meet client needs
7. Knowledge of appropriate disciplinary measures (client rights)
8. Ability to work with others
9. Common sense

These are the competency areas for which there is the broadest range of ability between superior and average workers. Supervisors distinguished the proficiency of superior and average Care Providers on all the major elements. Based on Care Provider mean self ratings, willingness to learn was the only major element which achieved a significance of difference between groups.

The major elements are used for outlining the general competency requirements for the position under

study. These are further defined by subelements and training subelements.

Required subelements. These competencies should be established as minimum criteria. Primoff suggests that these be used as absolute qualifications below which an applicant would not be acceptable. The results of this study indicate that required competencies of a Care Provider should be:

12. Ability to love
27. Stable mental health
31. Stable family
35. Basic intelligence/ability to learn
45. Sincerity
57. Ability to get to appointments
66. Good physical health
68. Persistance/endurance (determination)

Generally when rating these sorts of minimum competencies, a basic yes or no assessment is done and if there is a negative indicator for any of these, the home study or selection process is discontinued. Many of the characteristics included in this category are clearly not easily measured through objective tests and will require some level of clinical expertise.

Subelements. These are selection competency areas which should be carefully assessed during the home study

process. Since in this study all of the subelements also achieved high Training Values, it is recommended that only those subelements which attained Training Value scores of between 75 and 100 be considered during the selection and preservice training process. Items with Training Values over 100 may be less practical or realistic to expect. Competency areas which meet these specifications are:

General Personal Characteristics

17. Patience
19. Eagerness to learn
23. Initiative and ability to think for self
24. Adaptability/flexibility (59. Open to suggestions; willing to try new ideas)
26. Ability to follow directions
32. Respect for others
52. Self control

Teaching and Client Development

10. Overall teaching skills
47. Ability to teach client self-esteem, self-awareness
56. Ability to identify client skill needs
69. Ability to teach social skills

Health and Safety

51. Knowledge of fire prevention/fire safety
52. Knowledge of good nutrition

Behavior Management

67. Ability to set realisitc limits on client (e.g. food intake, television)

Counselling

33. Listening skills

Normalization

46. Knowledge of importance of age appropriate activities

None of the competencies grouped under the program maintenance, advocacy and legal rights or mental retardation realms scored both high enough in Item Index and low enough in Training Value to be considered practical or realistic to expect of applicants. These would therefore be recommended for inservice training and other forms of on the job development.

The content of the selection criteria listed above indicates a need for emphasis on personal characteristics during the selection process. These are considered necessary for adequate performance and are not easily acquired through traditional training processes. Therefore doubts or concerns about an applicant in any of these selection competency areas would have to be carefully evaluated prior to consideration for licensure.

Training subelements. The next group of competencies are those which are useful to increasing performance

capabilities. These are competencies which were rated high in Item Index and also very high in Training (TR = 101-125). Applicant Care Providers would be given high credit for possessing these competencies, but would not be penalized for lack of them. These are competency areas for which training or other forms of competency development would be most frequently designed and on which the main content of annual performance evaluations would be based. The results of this study indicate that Care Provider competencies such as this are:

General Personal Characteristics

29. Self assurance/self confidence
34. Ability to work with a variety of people (school administrators, medical personnel, social workers, agencies)
39. Objectivity (ability to remain impartial)
48. Communication skills

Teaching and Client Development

28. Ability to teach client decision making
30. Ability to teach client daily living skills
40. Ability to teach client respect for others
53. Ability to teach self-preservation

Health and Safety

13. Ability to recognize symptoms of health problems

Behavior Management

14. Ability to respond to client consistently (using consistent methods and approaches)

20. Home consistency (getting all members of household to work consistently with the client)

38. Skills in working with inappropriate behavior

Counselling

15. Ability to work with client's biological family

Normalization

16. Belief in continuous client learning

22. Ability to let go/give client independence

41. Knowledge of the danger of labelling

42. Belief in the right of the client to take risks

Program Maintenance

18. Cooperation with agency policies

Advocacy and Legal Rights

25. Knowledge of client's emotional rights

Mental Retardation

66. General knowledge about mental retardation

The remainder of the competency areas did not reach a high enough Item Index value to be considered as critical as other competency areas to basic performance as a Care Provider. They did however achieve a Training

Value of at least 75. Primoff considers those in the higher range of Training Value to indicate superior ability of a rare nature. He suggests that an applicant would be given high credit for these competencies. He also recommends that these be included in performance evaluations and advanced levels of training.

Those in the lower range of Training Value are not as critical to basic performance either. Attainment of these competencies however would not have as great an impact on performance as others. These would be open to more interpretation regarding inclusion in a competency based program.

The reader who is interested in these training competency areas is directed to Appendix C. This category of competence is composed of all items for which only the Training Value is underlined.

Demographic data. The demographic data also contributes to information related to the objectives of the study. Experience with mental retardation prior to working with Specialized Home Care and training other than that required by Specialized Home Care was more prevalent among the superior Care Providers in the sample. This information coupled with the fact that eagerness/willingness to learn and general knowledge about mental retardation achieved dual significance based upon both supervisory and

self ratings in the questionnaires provides a direction for identification of a highly desirable group of potential Care Providers. Recruitment efforts might best be directed to an audience already exposed to the mentally retarded through work or personal experience. Publicity procedures which emphasize the importance of training as both a requirement and benefit of working with Specialized Home Care might also be useful. By an approach which emphasizes both the importance and advantages of training offered through the program, the prospective applicant, with no previous training, can be realistically oriented to the training demands of the Care Provider responsibilities and those with previous training would hopefully find the opportunity for additional training desirable.

Recommendations for Further Development of a Competency Based Program

As discussed in Chapter One, the establishment of a valid competency based system involves several stages of development. This study was intended to provide the framework for a competency based system and therefore its specific focus was on competency specification. The results should therefore not be perceived as a final product but rather as an initial phase in the process of competency based system design.

The next stage of program development will require determination of if or how to assess applicant and incumbent Care Providers on competencies identified by the study and then to develop a useful and meaningful training program.

Prior to moving on to a discussion of these next stages, the utility of the data generated through the study should be addressed. Given the very wide discrepency between the results of the supervisory and self ratings in the second phase of the study, it would be worthwhile to consider a follow-up assessment of the results. The interview and follow-up procedures recommended by Pottinger and Klemp (1976) as part of the Behavioral Event Analysis methodology might prove useful for assessment of the study results. This would focus upon a search for the competencies which cause effective performance, not just those which are statistically significant. This technique is described as being more sensitive to the subtle, more covert differences between barely acceptable and outstanding performance.

McClelland and his associates at McBer & Co. have also developed follow-up procedures whereby hypotheses about competence are tested through actual competency evaluation of a superior and average sample, not just estimated rating of competency levels. They have administered both psychometric and psychosocial instruments to superior

and average groups to compare differences on instruments which measure actual proficiency on specific areas of competence. In this way the perceptual bias and subjectivity inherent in both self and supervisory ratings is removed.

Translating competencies into measurable terms. Whether the foundation of competencies identified through this study are further assessed or adopted without further modification, the next stage in a competency based program design will involved steps which lead to a specification of the competency areas in measurable terms and an agreed upon methodology for assessing an individual in each competency area.

Margolis (1979) recommends the use of Mager's goal analysis strategy for refining competency areas into measurable performance objectives. The goal analysis process involves developing responses to questions regarding a broader "goal" or competency area such as: What would someone say or do that would provide adequate evidence of achieving this competency? Who is someone who exemplifies achievement in the competency? What does he do or say that makes one willing to say he is an outstanding example of having achieved the goal? The answers to these types of questions lead to a definition of the broader competency area in more concrete, measurable terms.

This process might be carried out by individual agencies or programs involved in designing a competency based system or by an advisory body similar to the Job Element Panel composed of individuals with a broader range of experience and orientation.

Designing methods of assessment. Once measurable performance criteria are identified, decisions can be made about how to assess either applicant or incumbent Care Providers. For some of the knowledge and skill competencies a paper and pencil test may be an appropriate and perhaps a more objective method of measurement. For process or attitudinal competencies, such as many of those in the general personal characteristics realm, a standardized interview or simulation procedure might be indicated. For still others, the use of observation might be the best method of evaluation. Once again, the nature of performance criteria will be extremely useful in determining the most effective method of measurement.

Training and development. Measurable performance criteria also facilitate decision making on design of a plan for training and education. Instructional objectives, based on criteria, become the framework for a training curriculum. Following the philosophy of competency based education programs, the criteria to assess the "student" are made explicit and the "student" is held accountable

for meeting these criteria. Modes of instruction and performance outcomes are flexible with an emphasis on individual style.

With this sort of emphasis, training personnel for Specialized Home Care might develop a variety of training approaches and resources to address each individual instructional objective. Training processes can then be adapted to the personal choice and preferential learning style of the individual Care Provider. By individualizing training, the Care Provider becomes an active participant in the design of the learning process. Given a clear statement of performance criteria, the Care Provider becomes a part of all phases of training including needs assessment (through self assessment), instructional design or approach, and evaluation of learning outcomes. Such involvement may well increase motivation and commitment to achieving proficiency in a competency.

In summary, the competency areas identified in this study have provided general criteria for the design of a competency based Care Provider development program. Possible approaches for further development of the system have been presented in this section, emphasizing adherence to the qualities inherent in the competency based concept: accountability, individualization and relevance to performance on the job.

Recommendations for Future Research

Besides the program development activities addressed above, the author offers some comments about the research methodology of this study.

Panel involvement. Probably most significant to the study process has been the inclusion of Care Providers and line staff in both phases of the study. Participation of the consumer in the development and execution of the study is viewed as an instrumental factor for gaining support in application of the results. The author recommends increased use of the Job Element Panel in explaining and redefining competencies beyond a single meeting. Panel members might act as an advisory body throughout all phases of the study, offering more in-depth interpretation of their ratings and providing advice on the development of the questionnaire. Becoming familiar with the total process, they would then be excellent resources for further interpretation of the final results and generating policy statements for practice.

Modification of questionnaire administration. Also regarding methodology and discussed earlier in this chapter was the question of reliability in both self and supervisory ratings. The information derived from the questionnaire may not have warranted the major efforts

involved in administration across a large group of Care Providers. Were a similar study to be carried out, the author would recommend the administration of the questionnaire on a smaller random or matched sample. She would also recommend that administration of the questionnaire to supervisors be carried out first without soliciting the general rating of the worker. Following return of questionnaire ratings on individual items, the supervisor would be asked to provide the general rating of the worker and also to state the primary qualifications or characteristics of the Care Provider which contribute to this rating. By doing this, the potential for negative or positive skewing of responses might be reduced and the researcher would have additional information, from a supervisory perspective, about what is critical to performance.

Another method for assessing the validity of hypothetical competencies generated by the panel, described earlier in the chapter, is McClelland's Behavioral Event Analysis technique. Given time and funding, the author recommends use of this technique for future research.

Concluding Statements

The study has provided some broader insights into the Care Provider role and responsibility. It has clearly

established that a level of specialized expertise is essential to successful functioning as a Care Provider. The results of the study indicate that the notion of the Care Provider as a non-skilled foster parent acting upon good intentions alone is no longer viable. A wide range of competence is mandatory for even mediocre performance. And a still more intense level of competence within a number of disciplines appears to increase overall capacity of the Care Provider to effectively serve clientele.

The implications of classifying the Care Provider within a more professional status are, no doubt, complicated. As expectations for competence increase, the need to reassess the status and role of Care Providers, as defined by payment patterns and perceived relationships to the placement agencies, becomes imminent. The incentives and motivation of the Care Provider to assume professional functions will effect the implementation of any system which sets professional standards.

Finally, as important as accountability and quality assurance for services for persons with developmental disabilities are believed to be, the reality of locating persons interested in undergoing a more accountable and demanding system of assessment, credentialing and training must be considered. Motivational factors for becoming a Care Provider may not be compatible with the goals of a competency based system. Implementors of such

a system must be sensitive to potential misunderstanding of the intent of such a system. Care Providers, as well as staff, who have been operating within a much less structured system, may perceive it as punitive and rigid. Careful attention must be given to the manner and process for introduction of any innovation. A pilot study with a small group of Care Providers and staff, whereby feedback from the participants can be used for modification prior to broader implementation, might be one method for reducing potential resistence to change.

Summary

This chapter has provided a summative discussion of the study. Basic criteria for selection and training having been identified, decisions around continued development of a competency based program must be made. Some recommendations for proceeding with program development have been offered.

The methodology of the study and recommendations for future research have also been discussed in this chapter. Several modifications of the study process have been suggested. Alternative approaches to the second phase of the study have also been recommended.

Finally, the need for sensitivity to the implications of implementing a competency based program has been identified. Incentives for adopting such a system must be

considered and potential resistance to more accountability and structure must be addressed. The author has proposed that more reasonable payment patterns and greater recognition of the Care Provider's professional status may be necessary. Implementation of a competency based program on an initial experimental basis, prior to broader implementation, has also been suggested.

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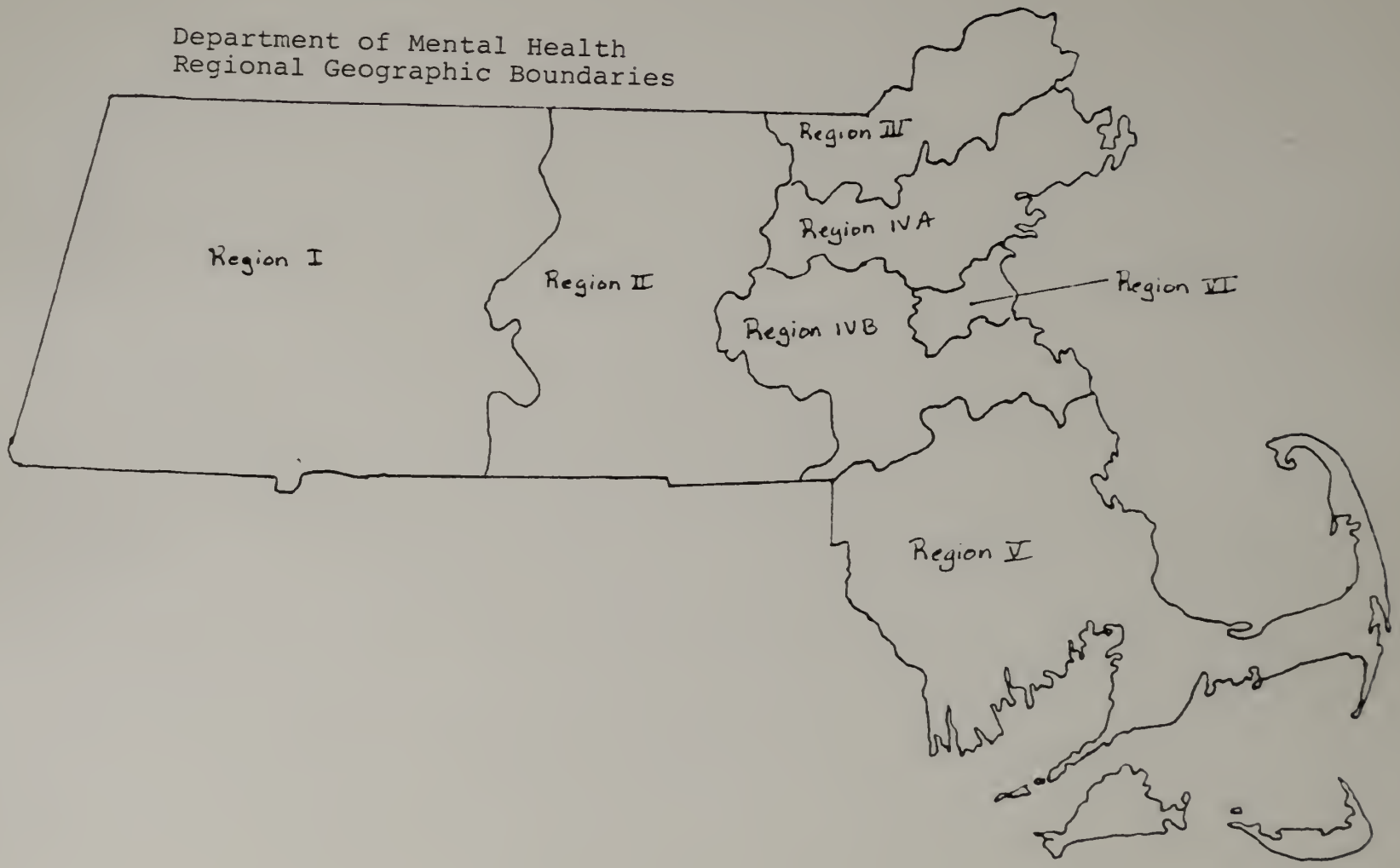
APPENDIX A

GEOGRAPHIC REGIONS REPRESENTED IN THE STUDY


Department of Mental Health
Regional Geographic Boundaries
Region I
Region II
Region III
Region IVA
Region IVB
Region VI
Region V

APPENDIX B

JOB ELEMENT RATING BLANKS

JOB ELEMENT RATING BLANK

Name:

ELEMENT NUMBER	How many BARELY ACCEPTABLE Care Providers have this element? + all have ✓ some have 0 almost none have	How important is this element in picking out a SUPERIOR Care Provider? + very important ✓ valuable 0 does not differentiate	How much TROUBLE is LIKELY if this element is not considered when selecting a Care Provider? + much trouble ✓ some trouble 0 safe to ignore	How PRACTICAL is this element? If we require it of applicant Care Providers we would probably approve: + all applicants ✓ some applicants 0 almost no applicants

	S X P	T	Item Index (IT) SP + T	Total Value (TV) IT + S -B - P	P' (+=0 ✓=1 0=2)	SP'	Training Value (TR) S + T + SP' - B

APPENDIX C

COMPETENCY AREAS FOR CARE PROVIDERS IDENTIFIED THROUGH THE JOB ELEMENT RATING SYSTEM

Competency Areas for Care Providers Identified through the Job Element Rating System

Listed below are the scores of 105 items rated high enough by the Job Element Panel to be considered Major Elements, Subelements or Training Subelements for further consideration in the study. They are listed in descending order of their Total Value (TV).

Major Elements are those items in which the TOTAL Value (TV) score is underlined. Based on the Job Element Rating system, these are the items in which the difference between barely acceptable and superior care providers is the greatest. Major Elements are considered the broad requirements for outstanding performance.

Subelements are those items in which the Item Index (IT) value is underlined. Subelements are usually important for consideration when selecting care providers. These items were rated as significant to outstanding performance as well as the likelihood of problems occurring if not possessed. Many of these, where the Training Value (TR) is also underlined, may also be increased through on the job experience or training and therefore should be considered for focus in orientation and training efforts, particularly preservice training.

Training Subelements, those in which only the Training Value (TV) is underlined, are those items which may not be practical to expect of applicant care providers, but which are somewhat related to good performance and potential trouble if not possessed. Training Subelements are usually considered when developing inservice training curricula.

Required Subelements, those in which the Barely Acceptable (B) and Trouble Likely (T) values are underlined, are those which a majority of the panel members indicated that even barely acceptable care providers would have. These might be used in establishing absolute minimum eligibility requirements for licensing as a care provider.

	Competency Areas	B	S	T	P	TV	IT	TR
1.	Understanding the client's feelings	25	100	95	60	115	72	125
2.	Honesty	45	100	90	60	113	70	113
3.	Ability to work with a variety of people	25	95	85	55	105	63	120
4.	Sensitivity to unspoken problems of client	20	100	85	50	105	58	138
5.	Understanding and accepting role with client	20	95	90	50	103	60	133
6.	Willingness to learn new skills to meet client needs	30	95	90	50	103	67	120
7.	Knowledge of appropriate disciplinary measures (client rights)	20	90	85	60	100	65	110
8.	Ability to work with others	30	95	95	50	100	62	128
9.	Commonsense	35	95	95	50	100	62	128
10.	Teaching skills	35	85	65	60	98	68	95
11.	Ability to pay attention to client	40	95	80	60	95	65	105
12.	Ability to love (R)	50	95	90	60	95	68	105
13.	Ability to recognize symptoms of health problems	40	90	80	55	93	62	103
14.	Ability to respond to client consistently	30	90	75	55	93	60	108
15.	Ability to work with client's biological family	20	90	80	55	93	58	115

	Competency Areas	B	S	T	P	TV	IT	TR
16.	Belief in continuous client learning	20	95	75	50	93	55	123
17.	Patience	45	90	85	50	90	65	100
18.	Cooperation with agency policies	30	80	95	11	90	62	108
19.	Eagerness to learn	20	85	80	60	90	57	113
20.	Home Consistency	20	90	75	45	90	53	115
21.	Compassion	30	85	70	65	88	62	90
22.	Ability to let go/ give client independence	40	90	80	55	88	60	105
23.	Initiative and ability to think for self	30	90	65	60	88	58	98
24.	Adaptability/ Flexibility	20	85	70	60	88	57	103
25.	Knowledge of client's emotional rights	20	90	75	45	88	50	125
26.	Ability to follow directions	45	90	80	55	85	60	100
27.	Stable mental health (R)	50	95	85	50	85	58	113
28.	Ability to teach client how to make his/her own decisions	30	85	65	50	85	55	105
29.	Self assurance/ self confidence	30	90	65	55	85	55	103
30.	Ability to teach daily living skills	25	85	65	55	85	53	118
31.	Stable family (R)	50	85	85	60	83	63	93
32.	Respect for others	40	85	80	55	83	58	100
33.	/Listening skills	30	85	60	60	83	55	93

	Competency Areas	B	S	T	P	TV	IT	TR
34.	Ability to work with a variety of people (school administrators, medical personnel, social workers, agencies	6	85	75	50	83	53	105
35.	Basic intelligence/ability to learn (R)	60	90	85	55	80	62	98
36.	Ability to say "no"	50	90	70	65	80	60	90
37.	Observation skills	25	80	70	60	80	55	95
38.	Skills in working with inappropriate behaviors	25	90	75	45	80	53	118
39.	Objectivity	45	70	55	55	80	52	103
40.	Ability to teach client respect for others	25	85	70	50	80	50	113
41.	Knowledge of the danger of labelling	30	85	70	45	80	50	108
42.	Belief in the right of the client to take risks	20	85	60	55	80	50	103
43.	Knowledge of client's right to privacy	30	90	70	45	80	48	118
44.	Advocating for client rights (support of client rights)	20	90	65	45	80	47	118
45.	Sincerity (R)	50	90	70	55	78	57	95
46.	Knowledge of importance of age-appropriate activities	45	85	80	55	78	57	100

	Competency Areas	B	S	T	P	TV	IT	TR
47.	Ability to teach client self-esteem/ self-awareness	35	80	80	55	78	55	100
48.	Communication skills	45	90	70	50	78	53	103
49.	Understanding of client's sexual rights	20	65	65	55	78	47	80
50.	Recognition of own limitations	25	65	65	55	78	47	80
51.	Knowledge of fire prevention/fire safety	45	80	75	50	75	55	90
52.	Self-control	35	80	75	55	75	53	95
53.	Ability to teach self-preservation	40	85	75	50	75	52	105
54.	Ability to understand client's biological family	20	80	75	50	75	48	110
55.	Understanding of client's legal rights	30	80	70	45	75	48	103
56.	Ability to identify client skill needs	40	85	65	50	73	50	98
57.	Ability to get to appointments (R)	55	80	65	60	70	55	75
58.	Knowledge of nutrition	45	85	60	50	70	50	90
59.	Open to suggestions/willing to try new ideas	30	75	65	55	70	50	88
60.	Knowledge of Care Provider rights	40	80	65	45	70	48	93
61.	Awareness of own weaknesses	20	70	75	55	70	48	78
62.	Ability to teach community skills/ socialization	30	80	55	50	70	45	93

	Competency Areas	B	S	T	P	TV	IT	TR
63.	Rapport with day program	20	80	30	65	70	40	108
64.	Clients	15	75	60	35	70	35	113
65.	General knowledge about mental retardation	45	90	65	10	<70	52	105
66.	Good physical health (R)	60	80	65	60	<70	52	73
67.	Ability to set realistic limits on client food intake, television, etc.	45	80	65	55	<70	52	85
68.	Persistance/ endurance	50	75	65	55	<70	50	103
69.	Ability to teach social skills	45	75	70	55	<70	50	85
70.	Determination	35	80	55	60	<70	50	83
71.	Homemaker skills (R)	60	60	60	60	<70	47	70
72.	Knowledge of normalization principle	35	80	65	40	<70	42	105
73.	Ability to break down task when teaching	30	70	60	30	<70	33	100
74.	Get all members of household to work consistently with client	30	75	65	45	<70	45	95
75.	Support counselling skills	20	70	60	45	<70	40	95
76.	Ability to read and interpret written information on client (R)	50	80	65	40	<70	45	93
77.	Understanding of SHCP service system	35	70	55	30	<70	33	93

	Competency Areas	B	S	T	P	TV	IT	TR
78.	Ability to set limits	35	75	60	55	<70	47	90
79.	Ability to accept mistakes of self and client	20	65	60	45	<70	40	90
80.	Ability to educate community about SCHP and mental retardation	20	70	50	40	<70	35	90
81.	Ability to teach sex education	35	70	65	45	<70	43	88
82.	First Aid, CPR, Heimlich	40	75	50	35	<70	37	88
83.	Medical knowledge	40	75	45	40	<70	37	88
84.	Ability to educate extended family members about SHCP and mental retardation	30	70	50	35	<70	35	88
85.	Ability to administer oral medications	55	80	70	50	<70	48	85
86.	Ability to compromise	30	70	55	45	<70	40	85
87.	Understanding of human sexuality	30	70	55	45	<70	40	85
88.	Ability to present a positive image of SHCP and work with the retarded	30	70	70	60	<70	48	80
89.	Ability to express feelings	45	70	70	60	<70	48	80
90.	Emergency procedures	55	75	65	45	<70	45	83
91.	Knowledge of appropriate bathing and dressing techniques for physically handicapped	35	65	60	35	<70	40	83

	Competency Area	B	S	T	P	TV	IT	TR
92.	Ability to teach client flexibility	20	65	50	45	<70	35	83
93.	Total communication skills	20	70	40	35	<70	35	83
94.	Ability to interpret nonverbal communications of client	40	70	55	45	<70	43	78
95.	Knowledge of history of mental retardation	40	70	50	40	<70	38	78
96.	Knowledge of authorizations to be maintained	45	70	60	50	<70	45	75
97.	Ability to teach hygiene	45	70	60	50	<70	45	75
98.	Advocacy	30	70	50	55	<70	43	75
99.	Not overprotective	45	70	55	55	<70	42	75
100.	Natural support system	35	70	50	60	<70	42	75
101.	Organizing skills	35	65	55	50	<70	38	75
102.	Ability to cope with seizures	45	65	60	40	<70	38	75
103.	Ability to teach client responsibility for self-medication	35	60	55	40	<70	35	75
104.	Knowledge of child development	45	70	60	55	<70	47	75
105.	Ability to pursue needed client information	40	70	50	50	<70	42	75
106.	Terminology in field of mental retardation	40	65	35	40	<70	42	75

Eliminated Items

The following is a list of items from the original list generated by the Job Element Panel. These items were not rated high enough by panel members to justify inclusion in the remainder of the study.

1. Ability to keep financial records
2. Knowledge of local resources
3. Knowledge of basic nursing
4. Understanding of DMH system
5. Education of professionals
6. Sense of timing
7. Physical therapy techniques
8. Occupational therapy techniques
9. Speech therapy
10. Knowledge of disabilities associated with retardation
11. Knowledge of community attitudes
12. Knowledge of day programs and what they should provide
13. Knowledge of transportation for the retarded
14. Knowledge of appeals processes (DMH, Dept. of Ed., Mass. Rehabilitation Commission)
15. Knowledge of alternative programs
16. Writing skills
17. Verbal skills
18. Ability to include client in household routines
19. Ability to organize leisure time activities
20. Ability to teach toileting skills
21. Ability to teach eating skills
22. Ability to teach dressing skills
23. Ability to teach travel/transporation skills
24. Ability to teach money management skills
25. Ability to teach household skills
26. Ability to administer injections

27. Knowledge of postural drainage techniques
28. Knowledge of positioning techniques
29. Knowledge of language development
30. Sense of humor
31. Insightful
32. Creativity
33. Physical strength
34. Training

APPENDIX D

CARE PROVIDER COVER LETTER AND QUESTIONNAIRE

Specialized Home Care

48 Revell Ave.
Northampton, Mass. 01060

Most experienced Care Providers would probably agree that being a Care Provider can sometimes be a very demanding job --- requiring a wide range of skills and qualities. Because of this, it is often difficult to know what important qualifications to look for when selecting Care Providers or what to include in training sessions and educational workshops.

Over the past three months, a few Care Providers and staff from across the state have been assisting in a study to describe what qualities, skills and areas of knowledge are most important to success as a Care Provider. While we've come up with lots of ideas, we don't know how realistic or how practical they are to actually being a Care Provider. For this reason, I am seeking the participation of Care Providers statewide to provide information about themselves and their own particular experiences and qualities. I am asking you to take 20 to 30 minutes out of your busy schedule to give your input and respond to the enclosed questionnaire. Through this questionnaire we hope to get some honest and candid information from a variety of Care Providers.

Some of the questions may seem difficult to answer or somewhat personal. It is important for you to know that your identity will never be known. The number on your questionnaire is for mailing and coding purposes only. Your individual responses will never be known by anyone.

This research will be used in the future selection of Care Providers and in planning workshops and training sessions. In order for the results to truly represent all Care Providers, it is essential that each questionnaire be completed and returned. The study should be finished within two months. If you are interested in the results, let a Specialized Home Care staff person know. Copies of the results will be available to Care Providers and staff shortly after the study is completed.

I would be happy to answer any questions you might have regarding this study. Please write or call. My telephone number is (413) 586-2424 (days) and (413) 584-1468 (evenings).

Thank you very much for your kind cooperation.

Sincerely,

Gretta Buckley
Region I Specialized Home Care

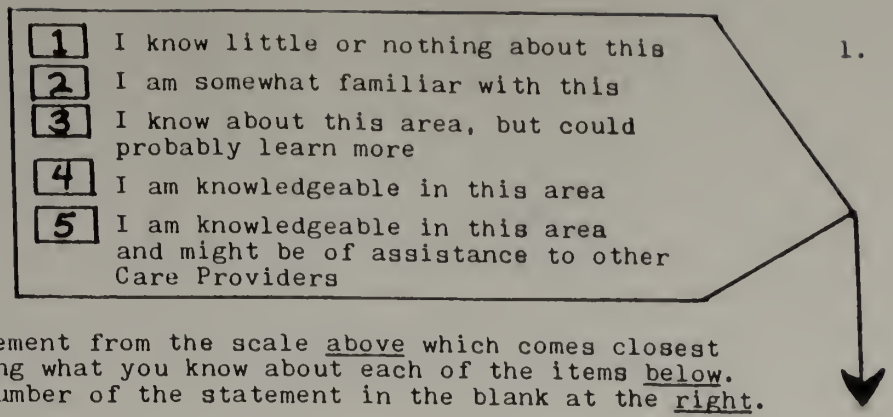
A STUDY OF CARE PROVIDERS IN MASSACHUSETTS

What makes them successful?

This survey is the final part of a study to find out more about the unique qualities of Care Providers. The information provided by you and other Care Providers will hopefully assist us in getting to know more about how to select Care Providers in the future and what to provide for training. Please answer all the questions. If you have any difficulties in completing any part of this survey, please call me collect at one of the numbers below and I will try to be of assistance.

Who should complete this?
For those homes which have more than one Care Provider, this questionnaire should be completed by the Care Provider who assumes the most day to day responsibility for the client(s).

Gretta Buckley
48 Revell Ave.
Northampton, Mass.
(413) 586-2424 (days)
(413) 584-1468 (evenings)



DIRECTIONS
Pick a statement from the scale above which comes closest to describing what you know about each of the items below. Place the number of the statement in the blank at the right.

1. Child Development . . . . . .____
2. Normalization . . . . . .____
3. The dangers of labelling clients . . . . . ____
4. The importance of age-appropriate activities for retarded people . . . . . .____
5. What to do in case of emergency . . . . . .____
6. SHCP authorizations/forms which must be kept by you . . . .____
7. First Aid . . . . . .____
8. CPR . . . . . .____
9. Heimlich maneuver . . . . . .____
10. Administration of oral medications . . . . . ____
11. How to handle seizures . . . . . ____
12. Correct and safe bathing and dressing techniques for physically handicapped clients . . . . . ____
13. Basic facts about good nutrition . . . . . ____
14. Basic rules of fire prevention and fire safety . . . . . ____
15. General knowledge about retardation (such as causes, treatment, etc.) . . . . . ____
16. Terms used in the field of mental retardation (such as "educable", "mainstreaming","time out", "less restrictive setting", etc.) . . . . . .____
17. The history or retardation (how it was managed in the past)____

2.

18. Total Communication . . . . . ___

19. Client's legal rights . . . . . ___

20. Emotional rights of clients . . . . . ___

21. Sexual rights of clients . . . . . ___

22. Your rights as a Care Provider . . . . . ___

23. Understanding human sexuality . . . . . ___

1 Not at all true
2 Slightly true
3 Partially true
4 Mostly true
5 Completely or almost completely true

DIRECTIONS
Pick a response from the scale above which most accurately describes the statements about you made below. Place the number of the response in the blank on the right.

24. I have a good understanding of Specialized Home Care services (who does what and who is responsible for what). ___

25. I have a good relationship with my client's day program. . ___

26. I have a circle of friends/relatives who support and assist me in my role as a Care Provider . . . . . ___

27. On the whole, I have good teaching skills . . . . . ___

28. I am overprotective of my client . . . . . ___

29. I am usually aware of my own limitations . . . . . ___

30. I have good listening skills . . . . . ___

Now go back and look over the items on pages 1 and 2. Pick out the five (5) which you feel are most important to your success as a Care Provider and put a check ✓ to the right of these items.

3.

0 Choose this response only if you can't think of any way this item applies to you

1 I don't feel capable in this area

2 I am somewhat capable, but often experience difficulty

3 I am capable, but could use help sometimes

4 I am capable in this area without assistance

5 I am very capable in this area and would probably be able to help other Care Providers

DIRECTIONS

Pick a statement from the scale above which best describes your ability in the items listed below. Place the number of the response in the blank at the right of each item.

31. Gaining information on your client through observation . . _____

32. Reading and interpreting written information on client (such as school reports, medical and psychological assessments, etc.) . . . . . _____

33. Getting necessary information on your client from others (social worker, doctor, teacher, etc.) . . . . . _____

34. Identifying your client's skill needs . . . . . _____

35. Organizing time and planning activities for your client . . _____

36. Teaching your client daily living skills (for example, eating, bathing, dressing, hygiene) . . . . . _____

37. Teaching your client self-preservation skills (such as how to react to potential injury, danger or harm) . . . . _____

38. Working on inappropriate ("acting out") behaviors of your client . . . . . _____

39. Using consistent methods and approaches with client . . . . _____

40. Breaking down task (into small steps) when teaching . . . . _____

41. Teaching your client flexibility (such as accepting changes or not always getting his/her way) . . . . . _____

42. Teaching your client self-esteem/self-awareness . . . . . _____

43. Teaching your client how to make his/her own decisions . . _____

44. Teaching your client respect for others . . . . . _____

45. Teaching your client about sexuality . . . . . _____

4.

46. Teaching your client community skills (such as how to use bus; how to shop; how to behave in public places) . . . . ____

47. Setting realistic limits for your client (such as food intake, television, etc.) . . . . . ____

48. Understanding the feelings of client's biological family . ____

49. Working with client's biological family . . . . . ____

50. Working with a variety of people (such as social workers, medical personnel, agencies, school administrators,etc.). ____

51. Providing supportive counselling to your client . . . . . ____

52. Being sensitive to unspoken problems of client . . . . . ____

53. Understanding your client's feelings . . . . . ____

54. Expressing your own feelings . . . . . ____

55. Interpreting non-verbal communications of your client . . . ____

56. Presenting a positive image of Specialized Home Care . . . ____

57. Presenting a positive image of working with the retarded . ____

58. Educating the general community about Specialized Home Care . . . . . ____

59. Educating the general community about mental retardation . ____

60. Educating your extended family members about Specialized Home Care . . . . . ____

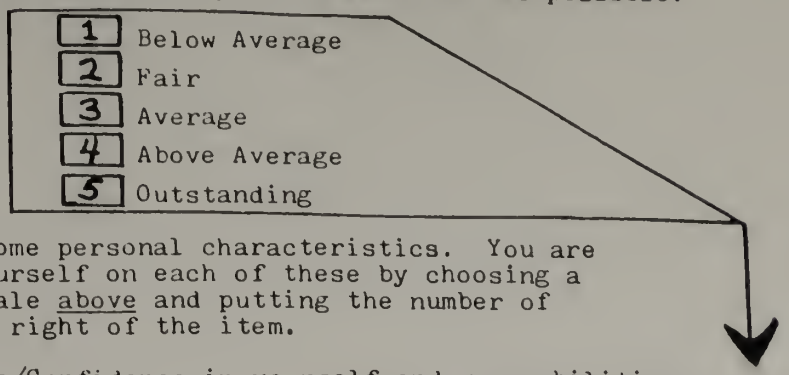
61. Educating your extended family members about mental retardation . . . . . ____

62. Recognizing symptoms of health problems . . . . . ____

63. Advocating for client rights . . . . . ____

Now look over the items on pages 3 & 4 and choose the 5 items which you feel are most important to your work as a Care Provider. Put a check ✓ next to each of those items.

In this section you will be asked about some of your personal qualities. While it is often difficult to rate yourself on these, try to be as honest as possible. 5.



DIRECTIONS

Below are listed some personal characteristics. You are asked to assess yourself on each of these by choosing a rating from the scale above and putting the number of that rating on the right of the item.

64. Self Assurance/Confidence in yourself and your abilities . ____

65. Persistance/Endurance (ability to remain firm in spite of opposition or difficulties) . . . . . ____

66. Patience (getting through disagreeable or stressful situations calmly and without complaint) . . . . . ____

67. Respect for others . . . . . ____

68. Self control . . . . . ____

69. Common sense . . . . . ____

70. Ability to manage and maintain a household . . . . . ____

71. Sincerity/Honesty . . . . . ____

72. Compassion (sensitivity for the distress of others and a strong desire to alleviate it) . . . . . ____

73. Flexibility (open to suggestions/willing to try new ideas .____

74. Objectivity (ability to see both sides of a situation) . . ____

Next just mark true [T] or false [F] for each of the statements about you made below

75. I sometimes feel resentful when I don't get my way . . . . ____

76. I am sometimes irritated by people who ask favors of me . .____

77. I have never been irked when people expressed ideas different from my own . . . . . .____

78. On a few occasions I have given up doing something because I thought too little of my ability . . . . . ____

79. I am always courteous, even to people who are disagreeable.____

6.

1 Almost always
2 Usually
3 Sometimes
4 Occasionally
5 Seldom

DIRECTIONS
Once again, pick a response from the scale above which you feel comes closest to describing you for each of the itmes below. Place the number of the response in the blank on the right.

80. I get all members of my household to work consistently with the client . . . . . ____

81. I am able to communicate information, thoughts or feelings in a way that is satisfactory and understood . . . . . ____

82. I have difficulty accepting the mistakes of my client . . . ____

83. I have difficulty accepting my own mistakes . . . . . ____

84. I cooperate with Specialized Home Care policies . . . . . ____

85. The clients in Specialized Home Care should be allowed to take risks . . . . . ____

86. I feel the clients in Specialized Home Care are capable of continuing to learn . . . . . ____

87. I believe that Care Providers can increase their skills . . ____

88. I am willing to learn new skills to meet my client's needs ____

89. I have difficulty following directions . . . . . ____

90. I am able to reach reasonable agreements with other agencies and staff involved with my client . . . . . ____

91. I have trouble getting to appointments and meetings on my client . . . . . ____

THANK YOU ! ! !

If you have any comments on this survey or suggestions on what would make your job as a Care Provider easier, please put them below. They will be included in the final report of this study.

APPENDIX E

SUPERVISORY QUESTIONNAIRE

Specialized Home Care

JOB ELEMENT ANALYSIS STUDY

CARE PROVIDER NAME:_____

This questionnaire is the final part of a study to find out more about the unique qualities of Care Providers. As the staff person working closely with this Care Provider, it is hoped that you will be able to rate this Care Provider on each of the items contained in the attached questionnaire. If you are not quite sure of how to rate this Care Provider on a particular item, use your best judgement. Since Care Providers are completing a similar self-assessment, your responses will be balanced out by the responses of the Care Provider. If you have absolutely no idea on how to rate the Care Provider on any one of the items, just mark a U (Unknown) next to that item.

For those homes which have more than one Care Provider, this questionnaire should be completed on the Care Provider who assumes the most day to day responsibility for the client(s).

If you have any difficulties in completing any part of this survey, please feel free to call me at one of the numbers below and I will try to be of assistance.

When you have completed this questionnaire, please remove this front sheet and return to me.

Thank you for your time and assistance.

Gretta Buckley
48 Revell Ave.
Northampton, Mass. 01060
(413) 586-2424 (days)
(413) 584-1468 (evenings)

CODE
NUMBER:_____

GENERAL RATING

In order to find out those skills, abilities and personal qualities unique to outstanding performance as a Care Provider, this study will be comparing the ratings of "superior" and "average" Care Providers. For this reason, you are asked to give a general rating of the Care Provider on this form as either superior or average in relation to other Care Providers you have known. A superior Care Provider would generally be one who is extremely competent and whom you would highly recommend to another regional or area Specialized Home Care Program.

My general rating of this Care Provider is:

_____Superior

_____Average

Please answer the questions below using the following scale:

1	Knows little or nothing about this
2	Is somewhat familiar with this
3	Knows about this area, but could probably learn more
4	Is knowledgeable in this area
5	Is knowledgeable in this area and might be of assistance to other Care Providers

Please write the number of the phrase which comes closest to describing what you think this Care Provider knows about each of the items below in the blank on the right.

1. Child Development . . . . . _____
2. Normalization . . . . . _____
3. The dangers of labelling clients . . . . . _____
4. The importance of age-appropriate activities for retarded people . . . . . _____
5. What to do in case of emergency . . . . . _____
6. SHCP authorizations/forms which must be kept by him/her . . . . . _____
7. First Aid . . . . . _____
8. CPR . . . . . _____
9. Heimlich Maneuver . . . . . _____
10. Administration of oral medications . . . . . _____
11. How to handle seizures . . . . . _____
12. Correct and safe bathing and dressing techniques for physically handicapped clients . . . . . _____
13. Basic facts about good nutrition . . . . . _____
14. Basic rules of fire prevention and fire safety . _____
15. General knowledge about retardation (such as causes, treatment, etc.) . . . . . _____
16. Terms used in the field of mental retardation (such as "educable", "mainstreaming", "time out", "less restrictive setting", etc.) _____

17. The history of retardation (how it was managed in the past) . . . . . ____

18. Total Communication . . . . . ____

19. Client's legal rights . . . . . ____

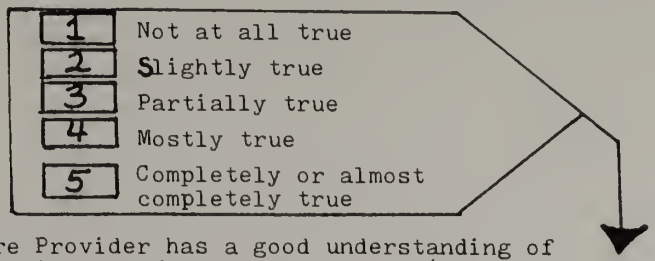
20. Emotional rights of clients . . . . . ____

21. Sexual rights of clients . . . . . ____

22. Her/his rights as a Care Provider . . . . . ____

23. Understanding human sexuality . . . . . ____

Please answer the questions below in the same way using the scale below.



24. This Care Provider has a good understanding of Specialized Home Care services (who does what and who is responsible for what) . . ____

25. This Care Provider has a good relationship with the client's day program . . . . . ____

26. This Care Provider has a circle of friends/ relatives who support and assist him/her as a Care Provider . . . . . ____

27. On the whole, this Care Provider has good teaching skills . . . . . ____

28. This Care Provider is overprotective of clients ____

29. This Care Provider is aware of his/her own limitations . . . . . ____

30. This Care Provider has good listening skills . . ____

Next please choose the response from the scale which most applies to this Care Provider for each of the items below.

0 - Choose this response only if you can't think of any way this item applies to this Care Provider
1 - Not very capable in this area
2 - Somewhat capable, but often experiences difficulty
3 - Capable, but could use help sometimes
4 - Capable in this area without assistance
5 - Very capable in this area and would probably be able to help other Care Providers

31. Gaining information on his/her client through observation . . . . . _____

32. Reading and interpreting written information on client (such as school reports, medical and psychological assessments, etc.) . . . _____

33. Getting necessary information on his/her client from others (social worker, doctor, etc.) _____

34. Identifying his/her client's skill needs . . . . _____

35. Organizing time and planning activities for the client . . . . . _____

36. Teaching client daily living skills (for example, eating, bathing, dressing, hygiene, etc.) . . . . . _____

37. Teaching client self-preservation skills . . . . _____

38. Working on inappropriate ("acting out") behaviors of his/her client . . . . . _____

39. Using consistent methods and approaches with client . . . . . _____

40. Breaking down task when teaching . . . . . _____

41. Teaching client flexibility . . . . . _____

42. Teaching client self-esteem/self-awareness . . . _____

43. Teaching client how to make his/her own decisions_____

44. Teaching client respect for others . . . . . _____

45. Teaching client about sexuality . . . . . ____

46. Teaching client community skills (such as how to use bus; how to shop; how to behave in public places) . . . . . ____

47. Setting realistic limits for client (such as food intake, television, etc.) . . . . . ____

48. Understanding the feelings of client's biological family . . . . . ____

49. Working with client's biological family . . . . ____

50. Working with a variety of people (for example, social workers, medical personnel, school administrators) . . . . . ____

51. Providing supportive counselling to his/her client . . . . . ____

52. Being sensitive to unspoken problems of client ____

53. Understanding his/her client's feelings . . . . ____

54. Expressing his/her <u>own</u> feelings . . . . . ____

55. Interpreting non-verbal communications of client____

56. Presenting a positive image of Specialized Home Care . . . . . ____

57. Presenting a positive image of working with the retarded . . . . . ____

58. Educating the general community about Specialized Home Care . . . . . ____

59. Educating the general community about mental retardation . . . . . ____

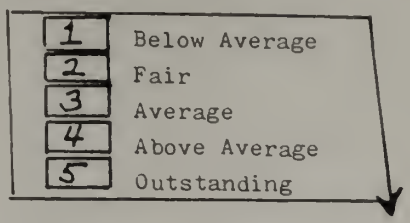
60. Educating his/her extended family members about Specialized Home Care . . . . . ____

61. Educating his/her extended family members about mental retardation . . . . . ____

62. Recognizing symptoms of health problems . . . . ____

63. Advocating for client rights . . . . . ____

Below are listed some personal characteristics. You are asked to assess this Care Provider on these by choosing a rating from the scale and putting the number of that rating on the right of the item.



64. Self Assurance/Self-confidence . . . . . .____

65. Persistance/Endurance (ability to remain firm in spite of opposition or difficulties) . . ____

66. Patience (getting through disagreeable or unpleasant situations calmly and without complaint) . . . . . .____

67. Respect for others . . . . . .____

68. Self control . . . . . .____

69. Common sense . . . . . .____

70. Ability to manage and maintain a household . . .____

71. Sincerity/Honesty . . . . . ____

72. Compassion (sensitivity for the distress of others and a strong desire to alleviate it) ____

73. Flexibility (open to suggestions and willing to try new ideas) . . . . . ____

74. Objectivity (ability to see both sides of a situation) . . . . . ____

* * * * * * * *

75. How long has this Care Provider been working with Specialized Home Care? _____

76. How many clients are currently placed with this Care Provider and what are their ages? _____

_____

77. Was this Care Provider ever involved with foster care before Specialized Home Care? YES___ NO____
If yes, what did he/she do?_____

_____

78. Did this Care Provider have any previous experience with the retarded prior to working with SHCP?
YES___ NO___ If yes, please describe:_____

_____

79. Has this Care Provider had any formal training related to foster care or retardation besides that provided by Specialized Home Care? YES___ NO___
If yes, please describe briefly:_____

_____

Once again pick a response from the scale which you feel comes closest to describing this Care Provider for each of the items below.

1	Almost always
2	Usually
3	Sometimes
4	Occasionally
5	Seldom

This Care Provider . . .

80. . .gets all members of his/her household to work consistently with the client . . . . . _____

81. . .is able to communicate information, thoughts or feelings in a way that is satisfactory and understood . . . . . _____

82. . .has difficulty accepting the mistakes of his/her client . . . . . _____

83. . .has difficulty accepting his/her own mistakes _____

84. . .cooperates with Specialized Home Care policies_____

85. . .believes that the clients in Specialized Home Care should be allowed to take risks . . . . _____

86. . .feels that the clients in Specialized Home Care are capable of continuing to learn . . _____

87. . .believes that Care Providers can increase their skills . . . . . _____

88. . .is willing to learn new skills to meet his/her client's needs . . . . . _____

89. . .has difficulty following directions . . . . . _____

90. . .is able to reach reasonable agreements with other agencies and staff involved with his/her client . . . . . _____

91. . .has trouble getting to appointments and meetings on behalf of his/her client . . . . _____

APPENDIX F

RESULTS OF INDIVIDUAL ITEM T-TESTS

T-TEST FOR INDIVIDUAL ITEMS OF GENERAL PERSONAL CHARACTERISTICS REALM

Item	Self Ratings				Supervisory Ratings			
	N $\bar{X}$ Avg.	N $\bar{X}$ Sup.	T-Val	Sig.	N $\bar{X}$ Avg.	N $\bar{X}$ Sup.	T-Val	Sig.
Friends/relatives who support and assist	46 4.15	65 4.36	.97	.334	46 3.63	65 4.47	4.55	$\leq$ .0001
Recognition of own limitations	46 4.19	65 4.21	.16	.866	47 2.78	65 3.92	6.64	$\leq$ .0001
Ability to work with variety of people	44 3.86	64 4.07	1.65	.102	47 3.08	65 4.07	5.78	$\leq$ .0001
Ability to express feelings	46 3.82	65 4.09	2.36	.02	47 3.31	65 4.15	5.54	$\leq$ .0001
Presenting a positive image of specialized Home Care	43 3.79	64 4.10	2.13	.036	46 3.15	65 4.46	7.45	$\leq$ .0001
Working with the retarded	44 3.88	63 4.22	2.46	.016	46 3.39	65 4.67	8.72	$\leq$ .0001
Self assurance/ confidence	46 3.47	65 3.67	1.37	.174	47 3.1	65 3.96	5.73	$\leq$ .0001
Patience	46 3.39	65 3.36	.13	.893	47 3.02	65 4.21	6.93	$\leq$ .0001
Respect for others	45 3.95	65 3.9	.37	.715	47 3.42	65 4.41	7.11	$\leq$ .0001

GENERAL PERSONAL CHARACTERISTICS REALM (Cont.)

Item	Self Ratings				Supervisory Ratings			
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.
Self Control	46	3.65	65	3.55	.64	.526	47	3.21	65	4.13	6.77	$\leq$ .0001
Common sense	46	4.04	65	4.04	.02	.986	47	3.34	65	4.53	9.69	$\leq$ .0001
Sincerity/ honesty	46	4.21	65	4.27	.42	.678	47	3.7	65	4.46	5.07	$\leq$ .0001
Compassion	46	4.26	65	4.13	.87	.385	47	3.53	65	4.52	7.09	$\leq$ .0001
Flexibility/ adaptability	46	3.56	65	3.81	1.71	.09	47	2.93	65	4.13	7.44	$\leq$ .0001
Objectivity	45	3.53	64	3.71	1.19	.238	46	2.8	65	4.0	7.76	$\leq$ .0001
Communication skills	45	4.26	65	4.29	.18	.859	47	3.76	65	4.7	6.8	$\leq$ .0001
Determination/ persistance	45	3.68	65	4.27	1.29	.2	46	3.6	65	4.4	5.45	$\leq$ .0001
Ability to accept mistakes of clients	45	4.17	64	4.15	.12	.906	47	3.53	65	4.47	5.16	$\leq$ .0001
Ability to accept own mistakes	44	3.81	65	3.6	1.06	.29	47	3.55	65	4.43	4.89	$\leq$ .0001

GENERAL PERSONAL CHARACTERISTICS REALM (Cont.)

Item	Self Ratings					Supervisory Ratings				
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.
Belief in Care Provider learnings	45	4.62	65	4.8	1.33	.189	47	3.87	65	4.73	5.0	$\leq$ .0001
Eagerness to learn	44	4.65	65	4.89	2.04	.046	47	3.72	65	4.7	6.04	$\leq$ .0001
Ability to follow directions	45	4.22	65	4.47	1.48	.143	47	3.87	65	4.8	6.38	$\leq$ .0001
Ability to get to appointments	45	4.26	65	4.26	.02	.981	47	3.34	65	4.69	2.0	$\leq$ .05

T-TEST FOR INDIVIDUAL ITEMS OF ADVOCACY AND LEGAL RIGHTS REALM

Item	Self Ratings				Supervisory Ratings			
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N $\bar{X}$ Avg.	N $\bar{X}$ Sup.	T-Val	Sig.
Knowledge of client legal rights	46	3.1	65	3.06	.29	.769	47 2.7	64 3.46	4.71	$\leq$ .0001
Knowledge of client emotional rights	44	3.25	65	3.23	.11	.911	47 2.97	65 3.8	5.06	$\leq$ .0001
Knowledge of care provider rights	46	3.3	65	3.33	.2	.844	47 2.7	64 3.51	4.76	$\leq$ .0001
Advocacy Skills	45	3.6	61	3.85	1.43	.156	47 3.19	64 3.84	4.23	$\leq$ .0001
Ability to compromise	45	4.24	65	4.55	1.77	.081	47 3.74	65 4.6	4.88	$\leq$ .0001
Knowledge of client sexual rights	44	3.04	65	3.16	.63	.531	47 2.7	64 3.51	4.76	$\leq$ .0001

T-TEST FOR INDIVIDUAL ITEMS OF BEHAVIOR MANAGEMENT REALM

Item	Self Ratings						Supervisory Ratings					
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.
Skills in working with inappropriate behavior	43	3.6	65	3.83	1.47	.145	46	2.82	63	3.73	5.26	$\leq$ .0001
Ability to respond to client consistently	45	3.68	65	4.03	2.54	.013	47	3.0	65	4.06	6.88	$\leq$ .0001
Ability to set realistic limits on client	45	3.8	65	4.07	2.68	.009	46	3.26	65	4.16	6.2	$\leq$ .0001
Home consistency	44	4.13	64	4.15	.12	.906	43	3.41	64	4.51	5.95	$\leq$ .0001

T-TEST FOR INDIVIDUAL ITEMS OF PROGRAM MAINTENANCE REALM

Item	Self Ratings				Supervisory Ratings			
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.
Understanding of SHCP service system	46	3.82	64	4.14	1.75	.084	47	3.61	65	4.44	5.59	$\leq$ .0001
Ability to establish a good relationship with client's day program	44	4.27	63	4.36	.5	.617	44	3.27	62	4.33	4.77	$\leq$ .0001
Ability to read and interpret written info on client	43	3.46	64	3.71	1.61	.112	47	3.0	65	3.72	4.29	$\leq$ .0001
Ability to pursue needed client information	46	3.76	65	3.87	.79	.432	47	3.19	65	4.09	4.17	$\leq$ .0001
Ability to cooperate with agency policies	44	4.36	65	4.72	2.26	.028	47	3.87	65	4.73	5.49	$\leq$ .0001

T-TEST FOR INDIVIDUAL ITEMS OF NORMALIZATION REALM

Item	Self Ratings				Supervisory Ratings			
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.
Knowledge of normalization principle	45	3.28	65	3.49	1.11	.272	47	2.87	64	3.98	6.31	$\leq$ .0001
Knowledge of the dangers of labelling	46	3.56	65	3.66	.46	.648	46	3.13	65	3.98	5.03	$\leq$ .0001
Knowledge of the importance of age appropriate activities	45	3.48	64	3.65	.87	.386	47	3.02	65	4.07	6.45	$\leq$ .0001
Not overprotective	45	3.17	65	3.52	1.26	.211	47	3.31	65	4.3	4.45	$\leq$ .0001
Belief in right of client risktaking	44	2.68	62	2.95	1.04	.302	47	3.04	65	4.18	4.85	$\leq$ .0001
Belief in continuous client learning	45	4.64	65	4.73	.73	.47	47	3.89	65	4.8	5.36	$\leq$ .0001

T-TESTS FOR INDIVIDUAL ITEMS OF COUNSELLING REALM

Item	Self Ratings						Supervisory Ratings					
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.
Listening skills	46	4.23	65	4.15	.52	.607	47	3.31	65	4.35	4.91	$\leq$ .0001
Understanding the feelings of client's biological family	36	3.66	56	3.71	.23	.816	38	3.34	60	3.93	2.92	$\leq$ .005
Ability to work with client's biological family	32	3.71	49	3.71	.02	.984	36	3.27	58	3.93	3.08	$\leq$ .003
Support counselling skills	41	3.6	57	3.98	2.73	.008	44	2.93	63	3.95	5.65	$\leq$ .0001
Sensitivity to unspoken problems of clients	44	3.72	65	3.83	.80	.428	47	3.14	64	4.21	6.51	$\leq$ .0001
Understanding the client's feelings	46	3.76	64	3.95	1.52	.132	47	3.17	65	4.2	6.38	$\leq$ .0001
Ability to interpret non-verbal communications of client	44	3.61	64	3.87	1.72	.088	46	3.02	65	4.06	5.88	$\leq$ .0001

T-TEST FOR INDIVIDUAL ITEMS OF TEACHING/CLIENT DEVELOPMENT REALM

Item	Self Ratings				Supervisory Ratings			
	N $\bar{X}$ Avg.	N $\bar{X}$ Sup.	T-Val	Sig.	N $\bar{X}$ Avg.	N $\bar{X}$ Sup.	T-Val	Sig.
Knowledge of child development	46 3.45	65 3.46	.03	.978	46 3.08	64 3.79	4.38	$\leq$ .0001
Total communication	45 3.13	65 3.04	.41	.68	44 2.29	60 3.0	3.28	$\leq$ .001
Knowledge of human sexuality	45 3.37	65 3.41	.21	.834	47 3.04	65 3.73	4.59	$\leq$ .0001
Overall teaching skills	46 4.17	65 4.41	1.67	.1	46 3.26	65 4.64	9.47	$\leq$ .0001
Observation skills	46 3.69	65 3.78	.57	.569	47 3.08	65 4.00	5.82	$\leq$ .0001
Ability to identify client skill needs	44 3.38	65 3.67	1.83	.07	47 2.87	65 3.96	7.37	$\leq$ .0001
Organizing skills	46 3.78	65 3.78	.02	.986	47 3.04	65 4.09	5.79	$\leq$ .0001
Ability to teach ADL	46 4.06	65 4.04	.15	.879	45 3.26	64 4.25	6.35	$\leq$ .0001
Ability to teach self-preservation	44 3.63	60 3.68	.35	.73	43 2.93	58 3.84	4.29	$\leq$ .0001

TEACHING/CLIENT DEVELOPMENT REALM (cont.)

Item	Self Ratings				Supervisory Ratings			
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.
Ability to break down task when teaching	46	3.6	65	3.83	1.57	.12	47	2.63	64	3.85	7.45	$\leq$ .0001
Ability to teach client flexibility	46	3.71	65	3.8	.59	.556	44	2.68	63	3.85	7.8	$\leq$ .0001
Ability to teach client self-esteem	45	3.73	64	3.73	.01	.994	46	2.89	63	4.12	6.77	$\leq$ .0001
Ability to teach client decision making	42	3.71	59	3.71	.02	.987	43	2.76	61	3.96	6.91	$\leq$ .0001
Ability to teach client respect for others	44	3.86	63	3.85	.05	.959	45	3.26	62	4.24	6.95	$\leq$ .0001
Ability to teach client about sexuality	37	3.08	56	3.10	.58	.565	44	2.15	57	3.4	6.91	$\leq$ .0001
Ability to teach client community skills	43	3.58	54	3.81	1.55	.125	43	2.97	55	3.94	5.54	$\leq$ .0001

T-TEST FOR INDIVIDUAL ITEMS OF MENTAL RETARDATION REALM

Item	Self Ratings						Supervisory Ratings					
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.
General knowledge about mental retardation	46	3.32	64	3.7	2.09	.04	47	2.95	65	3.74	4.65	$\leq$ .0001
Terms used in the field	45	3.17	64	3.59	2.02	.046	47	2.82	65	3.78	5.05	$\leq$ .0001
Knowledge of history of mental retardation	36	3.26	64	3.65	2.08	.041	47	2.7	75	3.26	2.94	$\leq$ .004
Ability to educate community about . . .												
--Specialized Home Care	44	3.5	63	3.93	2.22	.029	45	2.93	65	4.26	6.97	$\leq$ .0001
--Working with the retarded	44	3.36	62	3.95	2.76	.007	47	2.78	65	4.13	7.03	$\leq$ .0001
Ability to educate extended family members about . . .												
--Specialized Home Care	44	3.86	63	4.22	2.52	.014	47	3.23	65	4.41	6.76	$\leq$ .0001
--Working with the retarded	43	3.74	63	4.11	1.97	.053	47	2.97	65	4.43	8.60	$\leq$ .0001

T-TEST FOR INDIVIDUAL ITEMS OF HEALTH AND SAFETY REALM

Item	Self Ratings						Supervisory Ratings					
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup	T-Val	Sig.
Knowledge of emergency procedures	45	3.88	65	3.84	.29	.772	47	3.8	65	4.27	4.62	$\leq$ .0001
Knowledge of necessary authorizations/forms	43	3.51	64	3.23	1.29	.199	46	3.3	63	3.82	3.6	.001
Knowledge of first aid	45	3.48	64	3.32	.91	.366	45	3.24	62	3.74	2.81	.006
Knowledge of CPR	45	2.62	64	2.98	1.36	.177	36	2.38	56	3.32	3.59	.001
Knowledge of Heimlich maneuver	43	3.02	63	3.25	.9	.372	38	2.78	53	3.52	3.05	.003
Ability to administer oral medications	46	3.91	64	3.76	.79	.432	44	3.65	64	3.85	1.32	.191
Knowledge of how to handle seizures	45	3.26	65	3.35	.38	.707	40	3.3	60	3.45	.64	.522
Bathing and dressing techniques for physically handicapped	44	3.18	65	3.3	.54	.589	43	3.16	62	3.7	2.71	.008
Knowledge of nutrition	46	4.0	65	4.03	.25	.805	47	3.68	65	4.1	4.47	$\leq$ .0001

HEALTH AND SAFETY REALM (Cont.)

Item	Self Ratings						Supervisory Ratings					
	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.	N	$\bar{X}$ Avg.	N	$\bar{X}$ Sup.	T-Val	Sig.
Knowledge of fire prevention/fire safety	46	3.8	65	3.86	.51	.611	47	3.51	65	4.01	4.73	$\leq$ .0001
Ability to recognize symptoms of health problems	46	3.71	65	3.96	1.81	.074	47	3.89	65	4.29	3.15	.002
Homemaking skills	46	4.06	65	4.07	.08	.937	47	3.65	65	4.49	6.1	$\leq$ .0001